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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/25/2020 1:53 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/25/2020 Time: 1:53 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CAMERON MEMORIAL COMMUNITY HOSPITAL (15-1315) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 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	173,076	-1,095,861	0	-237,141	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	37,542	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		71,649		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	210,618	-1,024,212	0	-237,141	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2020 1:53 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 416 E MAUMEE STREET	PO Box:			1.00
2.00	City: ANGOLA	State: IN	Zip Code: 47803-	County: STEUBEN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CAMERON MEMORIAL COMMUNITY HOSPITAL	151315	99915	1	02/01/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	CAMERON HOME HEALTH CARE	157117	99915		04/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	CAMERON HOSPICE	151561	99915		05/01/1997				14.00
15.00	Hospital-Based Health Clinic - RHC	CAMERON FAMILY MEDICINE	158530	99915		12/31/2016	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2018	09/30/2019	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2020 1:53 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 1:53 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 1:53 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 1:53 pm

		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: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 1:53 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	Y	109.00

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

		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:	194,147	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: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 1:53 pm

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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)		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)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 1:53 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: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2020 1:53 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/19/2019	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/03/2019	Y	12/03/2019	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: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2020 1:53 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				Y	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/25/2020 1:53 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2020 1:53 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,395	77,616.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		23	8,395	77,616.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	3,264.00	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	80,880.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2020 1:53 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)	889	88	3,217			1.00
2.00	HMO and other (see instructions)	272	252				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	257	0	257			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	304			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,146	88	3,778			7.00
8.00	INTENSIVE CARE UNIT	43	13	136			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	468			13.00
14.00	Total (see instructions)	1,189	101	4,382	0.00	390.14	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	1,188	246	3,507	0.00	7.48	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	1.44	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,283	2,136	8,355	0.00	9.77	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	408.83	27.00
28.00	Observation Bed Days		112	1,086			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	7	17			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2020 1:53 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	343	40	1,262	1.00
2.00	HMO and other (see instructions)			89	118		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	343	40	1,262	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-7117 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-4 | Date/Time Prepared: 2/25/2020 1:53 pm

Home Health Agency I | PPS

						1.00	
0.00	County				STEUBEN		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	57.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.02	0.00	0.02	3.00
4.00	Director(s) and Assistant Director(s)			0.90	0.00	0.90	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			3.13	0.00	3.13	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.08	0.00	2.08	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.43	0.00	0.43	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.04	0.00	0.04	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.43	0.00	0.43	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.35	0.00	1.35	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	417	0	37	8	462	21.00
22.00	Skilled Nursing Visit Charges	76,888	0	6,610	1,555	85,053	22.00
23.00	Physical Therapy Visits	444	0	9	13	466	23.00
24.00	Physical Therapy Visit Charges	91,149	0	1,848	2,669	95,666	24.00
25.00	Occupational Therapy Visits	63	0	1	3	67	25.00
26.00	Occupational Therapy Visit Charges	12,511	0	199	596	13,306	26.00
27.00	Speech Pathology Visits	3	0	0	1	4	27.00
28.00	Speech Pathology Visit Charges	596	0	0	199	795	28.00
29.00	Medical Social Service Visits	17	0	0	1	18	29.00
30.00	Medical Social Service Visit Charges	3,950	0	0	247	4,197	30.00
31.00	Home Health Aide Visits	163	0	3	5	171	31.00
32.00	Home Health Aide Visit Charges	8,567	0	158	263	8,988	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,107	0	50	31	1,188	33.00
34.00	Other Charges	6,437	0	361	0	6,798	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	200,098	0	9,176	5,529	214,803	35.00
36.00	Total Number of Episodes (standard/non outlier)	63		15	1	79	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	6,437	0	1,069	23	7,529	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-8 | Date/Time Prepared: 2/25/2020 1:53 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1500 W MAUMEE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLOA		IN	46703	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1315
Component CCN: 15-8530

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-8
Date/Time Prepared:
2/25/2020 1:53 pm

RHC I | Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

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

Period: From 10/01/2018 To 09/30/2019

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	1,412	0	352	1,764	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	1,412	0	352	1,764	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-10 | Date/Time Prepared: 2/25/2020 1:53 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)	0.392497	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,179,212	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	14,737,986	6.00
7.00	Medicaid cost (line 1 times line 6)	5,784,615	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,605,403	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,605,403	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)	510,540	0	510,540	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	200,385	0	200,385	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)	200,385	0	200,385	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)	4,969,229	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	448,270	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	689,647	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,279,582	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,921,100	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,121,485	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,726,888	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,065,262	6,065,262	-582,322	5,482,940	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,189,196	2,189,196	2,254,340	4,443,536	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,502,533	7,502,533	0	7,502,533	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,940,295	8,868,675	12,808,970	132,945	12,941,915	5.00
7.00	00700	OPERATION OF PLANT	902,479	2,313,571	3,216,050	0	3,216,050	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,814	40,814	0	40,814	8.00
9.00	00900	HOUSEKEEPING	699,417	478,696	1,178,113	0	1,178,113	9.00
10.00	01000	DIETARY	454,704	357,254	811,958	-613,003	198,955	10.00
11.00	01100	CAFETERIA	0	0	0	603,028	603,028	11.00
13.00	01300	NURSING ADMINISTRATION	774,141	44,603	818,744	0	818,744	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	191,683	97,620	289,303	0	289,303	14.00
15.00	01500	PHARMACY	506,730	2,850,987	3,357,717	-145,220	3,212,497	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	499,859	61,815	561,674	0	561,674	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,101,247	1,018,039	3,119,286	520,691	3,639,977	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	117,514	117,514	31.00
43.00	04300	NURSERY	0	0	0	63,706	63,706	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,425,308	1,214,674	2,639,982	-634,248	2,005,734	50.00
51.00	05100	RECOVERY ROOM	0	0	0	634,248	634,248	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	956,754	228,482	1,185,236	-707,508	477,728	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,612,669	911,069	2,523,738	0	2,523,738	54.00
60.00	06000	LABORATORY	1,015,085	1,589,453	2,604,538	0	2,604,538	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	33,344	973,985	1,007,329	-88,861	918,468	65.00
65.01	06501	SLEEP LAB	0	0	0	101,641	101,641	65.01
66.00	06600	PHYSICAL THERAPY	918,051	30,620	948,671	0	948,671	66.00
69.00	06900	ELECTROCARDIOLOGY	0	422,572	422,572	-12,780	409,792	69.00
69.01	06901	CARDIAC REHAB	69,962	7,645	77,607	0	77,607	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,975,319	1,975,319	-1,087,850	887,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,087,850	1,087,850	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	1,492,288	1,492,288	0	1,492,288	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	853,439	91,637	945,076	0	945,076	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	138,393	24,871	163,264	0	163,264	90.00
90.01	09001	CLINIC- MCDONALD	562,341	1,131,286	1,693,627	0	1,693,627	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1,442,483	106,450	1,548,933	0	1,548,933	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	220,874	14,199	235,073	0	235,073	90.04
91.00	09100	EMERGENCY	1,910,478	276,233	2,186,711	5,597	2,192,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	601,367	114,946	716,313	-100,788	615,525	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,573,276	1,573,276	-1,573,276	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	65,987	18,687	84,674	12,745	97,419	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,897,090	44,086,757	65,983,847	-11,551	65,972,296	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	2,240	2,240	0	2,240	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	500	34,277	34,777	0	34,777	194.04
194.05	07955	MARKETING	325,411	565,284	890,695	40,838	931,533	194.05
194.06	07956	GUEST MEALS	0	0	0	9,975	9,975	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	1,477,384	213,722	1,691,106	-189,256	1,501,850	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	1,002,186	67,455	1,069,641	0	1,069,641	194.11
194.12	07962	TRINE STUDENT HEALTH	74,013	2,495	76,508	0	76,508	194.12
194.13	07963	OCCUPATIONAL HEALTH	299,299	147,428	446,727	0	446,727	194.13
194.14	07964	IMMUNIZATION CLINIC	48,701	1,177	49,878	145,220	195,098	194.14
194.15	07965	FOUNDATION	89,527	249,974	339,501	4,774	344,275	194.15
194.16	07967	RETAIL PHARMACY	0	63,435	63,435	0	63,435	194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	25,214,111	45,434,244	70,648,355	0	70,648,355	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-264,869	5,218,071		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-22,620	4,420,916		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-188,613	7,313,920		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,230,960	9,710,955		5.00
7.00	00700	OPERATION OF PLANT	-3,300	3,212,750		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,814		8.00
9.00	00900	HOUSEKEEPING	0	1,178,113		9.00
10.00	01000	DIETARY	-9,405	189,550		10.00
11.00	01100	CAFETERIA	-254,313	348,715		11.00
13.00	01300	NURSING ADMINISTRATION	0	818,744		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	289,303		14.00
15.00	01500	PHARMACY	-78,149	3,134,348		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-548	561,126		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-656,904	2,983,073		30.00
31.00	03100	INTENSIVE CARE UNIT	0	117,514		31.00
43.00	04300	NURSERY	0	63,706		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-564,512	1,441,222		50.00
51.00	05100	RECOVERY ROOM	0	634,248		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	477,728		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,523,738		54.00
60.00	06000	LABORATORY	-1,770	2,602,768		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	918,468		65.00
65.01	06501	SLEEP LAB	0	101,641		65.01
66.00	06600	PHYSICAL THERAPY	0	948,671		66.00
69.00	06900	ELECTROCARDIOLOGY	0	409,792		69.00
69.01	06901	CARDIAC REHAB	0	77,607		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	887,469		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,087,850		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	0	1,492,288		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	945,076		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	163,264		90.00
90.01	09001	CLINIC- MCDONALD	-1,255,931	437,696		90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	-1,310,240	238,693		90.02
90.03	09003	IV THERAPY	0	0		90.03
90.04	09004	OP PSYCH	0	235,073		90.04
91.00	09100	EMERGENCY	0	2,192,308		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	615,525		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	0	97,419		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,842,134	58,130,162		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0		194.00
194.01	07951	MOB	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	2,240		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0		194.03
194.04	07954	EDUCATION	0	34,777		194.04
194.05	07955	MARKETING	0	931,533		194.05
194.06	07956	GUEST MEALS	0	9,975		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0		194.07
194.08	07958	CANCER CENTER	0	0		194.08
194.09	07959	URGENT CARE	0	1,501,850		194.09
194.10	07960	RHC	0	0		194.10
194.11	07961	OBGYN	0	1,069,641		194.11
194.12	07962	TRINE STUDENT HEALTH	0	76,508		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	446,727		194.13
194.14	07964	IMMUNIZATION CLINIC	0	195,098		194.14
194.15	07965	FOUNDATION	0	344,275		194.15
194.16	07967	RETAIL PHARMACY	0	63,435		194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,842,134	62,806,221		200.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/25/2020 1:53 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LABOR AND DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	515,176	123,029		1.00
2.00	NURSERY	43.00	51,425	12,281		2.00
3.00	EMERGENCY	91.00	4,518	1,079		3.00
	0		571,119	136,389		
	B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	89,418		1.00
	0		0	89,418		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	337,701	265,327		1.00
2.00	GUEST MEALS	194.06	5,586	4,389		2.00
	0		343,287	269,716		
	D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,563,739		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,888		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	2,649		3.00
	0		0	1,573,276		
	E - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,247,452		1.00
	0		0	2,247,452		
	F - ICU					
1.00	INTENSIVE CARE UNIT	31.00	79,161	38,353		1.00
	0		79,161	38,353		
	H - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,973		1.00
	0		0	11,973		
	J - SLEEP LAB					
1.00	SLEEP LAB	65.01	0	101,641		1.00
2.00		0.00	0	0		2.00
	0		0	101,641		
	L - PUBLIC RELATIONS					
1.00	MARKETING	194.05	0	40,838		1.00
	0		0	40,838		
	M - HOME HEALTH SALARY					
1.00	HOME HEALTH AGENCY	101.00	25,808	0		1.00
	0		25,808	0		
	N - RECOVERY ROOM					
1.00	RECOVERY ROOM	51.00	634,248	0		1.00
	0		634,248	0		
	O - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,087,850		1.00
	0		0	1,087,850		
	P - HOME HEALTH ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	88,043	0		1.00
	0		88,043	0		
	Q - URGENT CARE					
1.00	ADMINISTRATIVE & GENERAL	5.00	189,256	0		1.00
	0		189,256	0		
	R - HOSPICE RECLASS					
1.00	HOSPICE	116.00	38,553	0		1.00
	0		38,553	0		
	S - FOUNDATION RECLASS					
1.00	FOUNDATION	194.15	4,774	0		1.00
	0		4,774	0		
	T - IMMUNIZATION CLINIC RECLASS					
1.00	IMMUNIZATION CLINIC	194.14	0	145,220		1.00
	TOTALS		0	145,220		
500.00	Grand Total: Increases		1,974,249	5,742,126		500.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/25/2020 1:53 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LABOR AND DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	571,119	136,389	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		571,119	136,389			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	89,418	12		1.00
	0		0	89,418			
	C - CAFETERIA						
1.00	DIETARY	10.00	343,287	269,716	0		1.00
2.00		0.00	0	0	0		2.00
	0		343,287	269,716			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,573,276	9		1.00
2.00		0.00	0	0	10		2.00
3.00		0.00	0	0	0		3.00
	0		0	1,573,276			
	E - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,247,452	9		1.00
	0		0	2,247,452			
	F - ICU						
1.00	ADULTS & PEDIATRICS	30.00	79,161	38,353	0		1.00
	0		79,161	38,353			
	H - PROPERTY TAX						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,973	13		1.00
	0		0	11,973			
	J - SLEEP LAB						
1.00	RESPIRATORY THERAPY	65.00	0	88,861	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	12,780	0		2.00
	0		0	101,641			
	L - PUBLIC RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	40,838	0		1.00
	0		0	40,838			
	M - HOME HEALTH SALARY						
1.00	HOSPICE	116.00	25,808	0	0		1.00
	0		25,808	0			
	N - RECOVERY ROOM						
1.00	OPERATING ROOM	50.00	634,248	0	0		1.00
	0		634,248	0			
	O - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,087,850	0		1.00
	0		0	1,087,850			
	P - HOME HEALTH ADMIN						
1.00	HOME HEALTH AGENCY	101.00	88,043	0	0		1.00
	0		88,043	0			
	Q - URGENT CARE						
1.00	URGENT CARE	194.09	189,256	0	0		1.00
	0		189,256	0			
	R - HOSPICE RECLASS						
1.00	HOME HEALTH AGENCY	101.00	38,553	0	0		1.00
	0		38,553	0			
	S - FOUNDATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	4,774	0	0		1.00
	0		4,774	0			
	T - IMMUNIZATION CLINIC RECLASS						
1.00	PHARMACY	15.00	0	145,220	0		1.00
	TOTALS		0	145,220			
500.00	Grand Total: Decreases		1,974,249	5,742,126			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2020 1:53 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,462,868	0	0	0	43,500	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	56,939,487	1,081,429	0	1,081,429	0	3.00
4.00	Building Improvements	20,000	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	19,354,014	1,115,107	0	1,115,107	468,955	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	77,776,369	2,196,536	0	2,196,536	512,455	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	77,776,369	2,196,536	0	2,196,536	512,455	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,419,368	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	58,020,916	0	3.00
4.00	Building Improvements	20,000	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	20,000,166	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79,460,450	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	79,460,450	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part II Date/Time Prepared: 2/25/2020 1:53 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	6,065,262	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,189,196	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,065,262	2,189,196	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	6,065,262	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,189,196	2.00
3.00	Total (sum of lines 1-2)	0	8,254,458	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2020 1:53 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	59,440,284	0	59,440,284	0.748049	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,020,166	0	20,020,166	0.251951	0	2.00
3.00	Total (sum of lines 1-2)	79,460,450	0	79,460,450	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,215,099	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,225,266	2,196,084	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,440,365	2,196,084	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-98,419	89,418	11,973	0	5,218,071	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-434	0	0	0	4,420,916	2.00
3.00	Total (sum of lines 1-2)	-98,853	89,418	11,973	0	9,638,987	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 2/25/2020 1:53 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-98,419	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-434	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	A	-167	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-12,779	CAP REL COSTS-MVBLE EQUIP	2.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,736,711			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	-356,347			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-237,840	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-78,149	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-548	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-14,343	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant	A	-149,102	CLINIC- MCDONALD	90.01	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 2/25/2020 1:53 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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-9,407	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	LOBBYING EXPENSES	A	-4,718	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	EMPLOYEE CHRISTMAS PARTY	A	-9,564	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN RECRUITMENT	A	-278,421	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MEALS ON WHEELS	B	-9,405	DIETARY	10.00	0	33.03
33.04	RENTAL INCOME OFFSET - CANCER CENTER	B	-32,316	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	ATM SURCHARGE REVENUE	B	-387	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	DIETICIAN CONSULTATIONS	B	-2,130	CAFETERIA	11.00	0	33.06
33.08	HAF EXPENSE	A	-2,901,749	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PHYSICIAN INCOME GUARANTEE OFFSET	A	793	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	NON PROVIDE CLINIC OFFSET	A	-903,544	CLINIC - FAM PRAC, PEDS, & ENT	90.02	0	33.10
33.11	MOVING EXPENSES	A	-6,447	ADMINISTRATIVE & GENERAL	5.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,842,134				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2020 1:53 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO OVERHEAD - BENEFITS	0	188,613	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	0	30,300	2.00
3.00	7.00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	0	3,300	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	CMO RENTAL	753,135	887,269	4.00
5.00	0		0	753,135	1,109,482	5.00

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

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

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

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

6.00	C	CAMERON MEDICAL	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet A-8-1 Date/Time Prepared: 2/25/2020 1:53 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-188,613	0		1.00
2.00	-30,300	0		2.00
3.00	-3,300	0		3.00
4.00	-134,134	9		4.00
5.00	-356,347			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2020 1:53 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	90.01	CLINIC- MCDONALD	1,106,829	1,106,829	0	0	0	1.00
2.00	60.00	LABORATORY	5,793	1,770	4,023	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	704,354	656,904	47,450	0	0	3.00
4.00	50.00	OPERATING ROOM	564,512	564,512	0	0	0	4.00
5.00	90.02	CLINIC - FAM PRAC, PEDS, & ENT	406,696	406,696	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,788,184	2,736,711	51,473		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	90.01	CLINIC- MCDONALD	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	90.02	CLINIC - FAM PRAC, PEDS, & ENT	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	90.01	CLINIC- MCDONALD	0	0	0	1,106,829		1.00
2.00	60.00	LABORATORY	0	0	0	1,770		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	656,904		3.00
4.00	50.00	OPERATING ROOM	0	0	0	564,512		4.00
5.00	90.02	CLINIC - FAM PRAC, PEDS, & ENT	0	0	0	406,696		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,736,711		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/25/2020 1:53 pm

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

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	26,786.00	1,108.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	64.62	66.30	66.30	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.15	33.15	33.15			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	1,775,912	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	73,460	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	1,775,912	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	1,775,912	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	1,775,912	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	12,100	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	12,100	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,186	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	13,286	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/25/2020 1:53 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	1,578.50	0.00	0.00	0.00	1,578.50	47.00
48.00	Overtime rate (see instructions)	99.45	99.45	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	156,981.83	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	66.30	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	137,904	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	137,904	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	104,655	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	33,249	0	0	0	33,249	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	1,775,912	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	33,249	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	1,809,161	63.00
64.00	Total cost of outside supplier services (from your records)	0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	12,100	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,186	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	13,286	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,186	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,186	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,218,071	5,218,071				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,420,916		4,420,916			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,313,920	27,056	16,733	7,357,709		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,710,955	485,768	382,706	1,229,346	11,808,775	5.00
7.00	00700	OPERATION OF PLANT	3,212,750	471,323	361,832	263,351	4,309,256	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,814	48,701	30,120	0	119,635	8.00
9.00	00900	HOUSEKEEPING	1,178,113	21,736	13,443	204,096	1,417,388	9.00
10.00	01000	DIETARY	189,550	195,903	121,159	32,512	539,124	10.00
11.00	01100	CAFETERIA	348,715	91,027	56,297	98,544	594,583	11.00
13.00	01300	NURSING ADMINISTRATION	818,744	32,375	50,880	225,901	1,127,900	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	289,303	142,892	88,374	55,935	576,504	14.00
15.00	01500	PHARMACY	3,134,348	52,965	32,757	147,868	3,367,938	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	561,126	0	31,396	145,863	738,385	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,983,073	745,870	461,297	740,396	4,930,636	30.00
31.00	03100	INTENSIVE CARE UNIT	117,514	54,112	33,466	23,100	228,192	31.00
43.00	04300	NURSERY	63,706	19,260	11,912	15,006	109,884	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,441,222	498,470	308,286	230,838	2,478,816	50.00
51.00	05100	RECOVERY ROOM	634,248	325,909	201,563	185,079	1,346,799	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	477,728	155,136	95,946	112,532	841,342	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,523,738	390,797	241,694	470,591	3,626,820	54.00
60.00	06000	LABORATORY	2,602,768	127,209	78,674	296,211	3,104,862	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	918,468	23,571	14,578	9,730	966,347	65.00
65.01	06501	SLEEP LAB	101,641	0	73,739	0	175,380	65.01
66.00	06600	PHYSICAL THERAPY	948,671	275,466	170,366	267,896	1,662,399	66.00
69.00	06900	ELECTROCARDIOLOGY	409,792	17,288	10,692	0	437,772	69.00
69.01	06901	CARDIAC REHAB	77,607	36,457	22,547	20,416	157,027	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	887,469	0	0	0	887,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,087,850	0	0	0	1,087,850	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	1,492,288	509,017	314,809	0	2,316,114	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	945,076	0	192,544	249,041	1,386,661	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	163,264	0	15,088	40,384	218,736	90.00
90.01	09001	CLINIC- MCDONALD	437,696	0	129,667	164,096	731,459	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	238,693	0	71,016	420,930	730,639	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	235,073	0	50,114	64,453	349,640	90.04
91.00	09100	EMERGENCY	2,192,308	437,663	270,679	558,813	3,459,463	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	615,525	0	35,168	146,073	796,766	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	97,419	0	35,168	22,975	155,562	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,130,162	5,185,971	4,024,710	6,441,976	56,786,123	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,597	16,449	0	43,046	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	15,003	0	15,003	194.01
194.02	07952	COMMUNITY HEALTH	2,240	0	0	0	2,240	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	34,777	0	0	146	34,923	194.04
194.05	07955	MARKETING	931,533	0	31,481	94,958	1,057,972	194.05
194.06	07956	GUEST MEALS	9,975	0	0	1,630	11,605	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	1,501,850	0	178,307	375,887	2,056,044	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	1,069,641	0	99,151	292,447	1,461,239	194.11
194.12	07962	TRINE STUDENT HEALTH	76,508	0	0	21,598	98,106	194.12
194.13	07963	OCCUPATIONAL HEALTH	446,727	0	24,022	87,338	558,087	194.13
194.14	07964	IMMUNIZATION CLINIC	195,098	0	3,432	14,211	212,741	194.14

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.15	07965	FOUNDATION	344,275	5,503	3,403	27,518	380,699	194.15
194.16	07967	RETAIL PHARMACY	63,435	0	24,958	0	88,393	194.16
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	62,806,221	5,218,071	4,420,916	7,357,709	62,806,221	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,808,775					5.00
7.00	00700	OPERATION OF PLANT	997,834	5,307,090				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,702	43,678	191,015			8.00
9.00	00900	HOUSEKEEPING	328,205	19,495	43,137	1,808,225		9.00
10.00	01000	DIETARY	124,837	175,701	470	19,504	859,636	10.00
11.00	01100	CAFETERIA	137,679	81,640	1,450	59,926	0	11.00
13.00	01300	NURSING ADMINISTRATION	261,172	73,784	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	133,493	128,156	0	10,176	0	14.00
15.00	01500	PHARMACY	779,866	47,503	0	15,829	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	170,977	45,529	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,141,731	668,955	37,791	525,481	824,760	30.00
31.00	03100	INTENSIVE CARE UNIT	52,839	48,532	1,568	9,893	34,876	31.00
43.00	04300	NURSERY	25,444	17,274	11,629	152,923	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	573,985	447,066	14,816	136,811	0	50.00
51.00	05100	RECOVERY ROOM	311,859	292,300	9,688	89,323	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	194,818	139,137	3,393	39,008	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	839,812	350,497	17,250	126,070	0	54.00
60.00	06000	LABORATORY	718,949	114,090	834	68,688	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	223,763	21,140	32	19,504	0	65.00
65.01	06501	SLEEP LAB	40,610	106,934	2,023	17,525	0	65.01
66.00	06600	PHYSICAL THERAPY	384,938	247,059	3,966	68,688	0	66.00
69.00	06900	ELECTROCARDIOLOGY	101,369	15,505	0	0	0	69.00
69.01	06901	CARDIAC REHAB	36,361	32,697	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	205,499	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	251,898	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	536,310	456,526	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	321,090	279,221	1,999	56,251	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	50,650	21,880	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	169,374	188,039	1,561	65,579	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	169,184	102,986	1,304	54,838	0	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	80,961	72,674	0	0	0	90.04
91.00	09100	EMERGENCY	801,059	392,530	38,033	255,814	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	184,496	50,999	71	1,413	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	36,021	50,999	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,414,785	4,732,526	191,015	1,793,244	859,636	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,968	23,854	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	3,474	21,757	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	519	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	8,087	0	0	0	0	194.04
194.05	07955	MARKETING	244,980	45,653	0	0	0	194.05
194.06	07956	GUEST MEALS	2,687	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	476,089	258,574	0	14,981	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	338,359	143,785	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	22,717	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	129,228	34,836	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	49,261	4,977	0	0	0	194.14
194.15	07965	FOUNDATION	88,153	4,935	0	0	0	194.15
194.16	07967	RETAIL PHARMACY	20,468	36,193	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,808,775	5,307,090	191,015	1,808,225	859,636	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	875,278					11.00
13.00	01300	NURSING ADMINISTRATION	29,606	1,492,462				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,101	0	866,430			14.00
15.00	01500	PHARMACY	20,394	0	3,969	4,235,499		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,230	0	62	0	999,183	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	166,133	635,820	26,344	0	7,512	30.00
31.00	03100	INTENSIVE CARE UNIT	5,556	21,254	1,032	0	616	31.00
43.00	04300	NURSERY	2,437	9,272	0	0	1,968	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,667	178,578	78,783	0	19,266	50.00
51.00	05100	RECOVERY ROOM	34,588	132,417	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,172	69,506	12,682	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,198	0	12,125	0	179,711	54.00
60.00	06000	LABORATORY	76,524	0	203,073	0	295,647	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,039	0	8,260	0	23,261	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	52,868	0	2,112	0	79,485	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	741	0	43,401	69.00
69.01	06901	CARDIAC REHAB	4,194	0	415	0	22,137	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	197,921	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	242,610	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,235,499	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,536	0	62,771	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,997	34,364	4,394	0	31,663	90.00
90.01	09001	CLINIC- MCDONALD	27,527	0	1,707	0	24,158	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	35,950	0	3,306	0	51,954	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	6,559	0	137	0	4,019	90.04
91.00	09100	EMERGENCY	107,456	411,251	31,946	0	114,482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	26,810	0	1,284	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	5,161	0	42	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	824,167	1,492,462	835,481	4,235,499	962,051	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	6,989	0	0	0	0	194.04
194.05	07955	MARKETING	10,753	0	382	0	0	194.05
194.06	07956	GUEST MEALS	645	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	23,785	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	32,724	0	1,885	0	37,132	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	555	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	3,574	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	262	0	0	194.14
194.15	07965	FOUNDATION	0	0	506	0	0	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/25/2020 1:53 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
202.00	TOTAL (sum lines 118 through 201)	875,278	1,492,462	866,430	4,235,499	999,183	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,965,163	0	8,965,163		30.00
31.00	03100	INTENSIVE CARE UNIT	404,358	0	404,358		31.00
43.00	04300	NURSERY	330,831	0	330,831		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,974,788	0	3,974,788		50.00
51.00	05100	RECOVERY ROOM	2,216,974	0	2,216,974		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,318,058	0	1,318,058		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,237,483	0	5,237,483		54.00
60.00	06000	LABORATORY	4,582,667	0	4,582,667		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,263,346	0	1,263,346		65.00
65.01	06501	SLEEP LAB	342,472	0	342,472		65.01
66.00	06600	PHYSICAL THERAPY	2,501,515	0	2,501,515		66.00
69.00	06900	ELECTROCARDIOLOGY	598,788	0	598,788		69.00
69.01	06901	CARDIAC REHAB	252,831	0	252,831		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,290,889	0	1,290,889		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,582,358	0	1,582,358		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,235,499	0	4,235,499		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	3,308,950	0	3,308,950		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,110,529	0	2,110,529		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	370,684	0	370,684		90.00
90.01	09001	CLINIC- MCDONALD	1,209,404	0	1,209,404		90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1,150,161	0	1,150,161		90.02
90.03	09003	IV THERAPY	0	0	0		90.03
90.04	09004	OP PSYCH	513,990	0	513,990		90.04
91.00	09100	EMERGENCY	5,612,034	0	5,612,034		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,061,839	0	1,061,839		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	247,785	0	247,785		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,683,396	0	54,683,396		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	76,868	0	76,868		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	40,234	0	40,234		194.01
194.02	07952	COMMUNITY HEALTH	2,759	0	2,759		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	49,999	0	49,999		194.04
194.05	07955	MARKETING	1,359,740	0	1,359,740		194.05
194.06	07956	GUEST MEALS	14,937	0	14,937		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	2,829,473	0	2,829,473		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	2,015,124	0	2,015,124		194.11
194.12	07962	TRINE STUDENT HEALTH	121,378	0	121,378		194.12
194.13	07963	OCCUPATIONAL HEALTH	725,725	0	725,725		194.13
194.14	07964	IMMUNIZATION CLINIC	267,241	0	267,241		194.14
194.15	07965	FOUNDATION	474,293	0	474,293		194.15
194.16	07967	RETAIL PHARMACY	145,054	0	145,054		194.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/25/2020 1:53 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	62,806,221	0	62,806,221		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	27,056	16,733	43,789	43,789	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	485,768	382,706	868,474	7,306	5.00
7.00	00700	OPERATION OF PLANT	0	471,323	361,832	833,155	1,568	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,701	30,120	78,821	0	8.00
9.00	00900	HOUSEKEEPING	0	21,736	13,443	35,179	1,215	9.00
10.00	01000	DIETARY	0	195,903	121,159	317,062	194	10.00
11.00	01100	CAFETERIA	0	91,027	56,297	147,324	587	11.00
13.00	01300	NURSING ADMINISTRATION	0	32,375	50,880	83,255	1,345	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	142,892	88,374	231,266	333	14.00
15.00	01500	PHARMACY	0	52,965	32,757	85,722	880	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	31,396	31,396	868	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	745,870	461,297	1,207,167	4,407	30.00
31.00	03100	INTENSIVE CARE UNIT	0	54,112	33,466	87,578	138	31.00
43.00	04300	NURSERY	0	19,260	11,912	31,172	89	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	498,470	308,286	806,756	1,374	50.00
51.00	05100	RECOVERY ROOM	0	325,909	201,563	527,472	1,102	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	155,136	95,946	251,082	670	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	390,797	241,694	632,491	2,801	54.00
60.00	06000	LABORATORY	0	127,209	78,674	205,883	1,763	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	23,571	14,578	38,149	58	65.00
65.01	06501	SLEEP LAB	0	0	73,739	73,739	0	65.01
66.00	06600	PHYSICAL THERAPY	0	275,466	170,366	445,832	1,595	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,288	10,692	27,980	0	69.00
69.01	06901	CARDIAC REHAB	0	36,457	22,547	59,004	122	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	509,017	314,809	823,826	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	192,544	192,544	1,482	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	15,088	15,088	240	90.00
90.01	09001	CLINIC- MCDONALD	0	0	129,667	129,667	977	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0	0	71,016	71,016	2,506	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	0	0	50,114	50,114	384	90.04
91.00	09100	EMERGENCY	0	437,663	270,679	708,342	3,326	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	35,168	35,168	870	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	35,168	35,168	137	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,185,971	4,024,710	9,210,681	38,337	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,597	16,449	43,046	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	15,003	15,003	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	1	194.04
194.05	07955	MARKETING	0	0	31,481	31,481	565	194.05
194.06	07956	GUEST MEALS	0	0	0	0	10	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	178,307	178,307	2,237	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	99,151	99,151	1,741	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	129	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	24,022	24,022	520	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	3,432	3,432	85	194.14
194.15	07965	FOUNDATION	0	5,503	3,403	8,906	164	194.15

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
194.16	07967	RETAIL PHARMACY	0	0	24,958	24,958	0	194.16
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,218,071	4,420,916	9,638,987	43,789	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	875,780					5.00
7.00	00700	OPERATION OF PLANT	74,003	908,726				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,054	7,479	88,354			8.00
9.00	00900	HOUSEKEEPING	24,341	3,338	19,954	84,027		9.00
10.00	01000	DIETARY	9,258	30,085	217	906	357,722	10.00
11.00	01100	CAFETERIA	10,211	13,979	671	2,785	0	11.00
13.00	01300	NURSING ADMINISTRATION	19,369	12,634	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,900	21,944	0	473	0	14.00
15.00	01500	PHARMACY	57,838	8,134	0	736	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,680	7,796	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,676	114,542	17,480	24,418	343,209	30.00
31.00	03100	INTENSIVE CARE UNIT	3,919	8,310	725	460	14,513	31.00
43.00	04300	NURSERY	1,887	2,958	5,379	7,106	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,569	76,551	6,853	6,358	0	50.00
51.00	05100	RECOVERY ROOM	23,129	50,050	4,481	4,151	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,448	23,824	1,569	1,813	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,283	60,015	7,979	5,858	0	54.00
60.00	06000	LABORATORY	53,320	19,536	386	3,192	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,595	3,620	15	906	0	65.00
65.01	06501	SLEEP LAB	3,012	18,310	936	814	0	65.01
66.00	06600	PHYSICAL THERAPY	28,548	42,304	1,834	3,192	0	66.00
69.00	06900	ELECTROCARDIOLOGY	7,518	2,655	0	0	0	69.00
69.01	06901	CARDIAC REHAB	2,697	5,599	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,241	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,682	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	39,775	78,170	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	23,813	47,811	925	2,614	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	3,756	3,747	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	12,561	32,198	722	3,047	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	12,547	17,634	603	2,548	0	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	6,004	12,444	0	0	0	90.04
91.00	09100	EMERGENCY	59,409	67,212	17,592	11,888	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	13,683	8,733	33	66	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	2,671	8,733	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	772,397	810,345	88,354	83,331	357,722	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	739	4,085	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	258	3,725	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	38	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	600	0	0	0	0	194.04
194.05	07955	MARKETING	18,169	7,817	0	0	0	194.05
194.06	07956	GUEST MEALS	199	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	35,308	44,275	0	696	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	25,094	24,620	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	1,685	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	9,584	5,965	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	3,653	852	0	0	0	194.14
194.15	07965	FOUNDATION	6,538	845	0	0	0	194.15
194.16	07967	RETAIL PHARMACY	1,518	6,197	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	875,780	908,726	88,354	84,027	357,722	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	175,557					11.00
13.00	01300	NURSING ADMINISTRATION	5,938	122,541				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,630	0	267,546			14.00
15.00	01500	PHARMACY	4,091	0	1,226	158,627		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,871	0	19	0	61,630	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,323	52,207	8,135	0	463	30.00
31.00	03100	INTENSIVE CARE UNIT	1,114	1,745	319	0	38	31.00
43.00	04300	NURSERY	489	761	0	0	121	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,360	14,662	24,328	0	1,188	50.00
51.00	05100	RECOVERY ROOM	6,937	10,872	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,645	5,707	3,916	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,088	0	3,744	0	11,085	54.00
60.00	06000	LABORATORY	15,349	0	62,707	0	18,236	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	208	0	2,551	0	1,435	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	10,604	0	652	0	4,903	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	229	0	2,677	69.00
69.01	06901	CARDIAC REHAB	841	0	128	0	1,365	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	61,117	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	74,913	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	158,627	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	783	0	3,872	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,804	2,821	1,357	0	1,953	90.00
90.01	09001	CLINIC- MCDONALD	5,521	0	527	0	1,490	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	7,211	0	1,021	0	3,205	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	1,316	0	42	0	248	90.04
91.00	09100	EMERGENCY	21,553	33,766	9,865	0	7,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,377	0	397	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,035	0	13	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,305	122,541	257,989	158,627	59,340	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	1,402	0	0	0	0	194.04
194.05	07955	MARKETING	2,157	0	118	0	0	194.05
194.06	07956	GUEST MEALS	129	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	7,345	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	6,564	0	582	0	2,290	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	171	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	1,104	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	81	0	0	194.14
194.15	07965	FOUNDATION	0	0	156	0	0	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/25/2020 1:53 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
202.00	TOTAL (sum lines 118 through 201)	175,557	122,541	267,546	158,627	61,630	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,890,027	0	1,890,027		30.00
31.00	03100	INTENSIVE CARE UNIT	118,859	0	118,859		31.00
43.00	04300	NURSERY	49,962	0	49,962		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	989,999	0	989,999		50.00
51.00	05100	RECOVERY ROOM	628,194	0	628,194		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	306,674	0	306,674		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,344	0	803,344		54.00
60.00	06000	LABORATORY	380,372	0	380,372		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	63,537	0	63,537		65.00
65.01	06501	SLEEP LAB	96,811	0	96,811		65.01
66.00	06600	PHYSICAL THERAPY	539,464	0	539,464		66.00
69.00	06900	ELECTROCARDIOLOGY	41,059	0	41,059		69.00
69.01	06901	CARDIAC REHAB	69,756	0	69,756		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,358	0	76,358		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93,595	0	93,595		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,627	0	158,627		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	941,771	0	941,771		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	273,844	0	273,844		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	30,766	0	30,766		90.00
90.01	09001	CLINIC- MCDONALD	186,710	0	186,710		90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	118,291	0	118,291		90.02
90.03	09003	IV THERAPY	0	0	0		90.03
90.04	09004	OP PSYCH	70,552	0	70,552		90.04
91.00	09100	EMERGENCY	940,014	0	940,014		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	64,327	0	64,327		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	47,757	0	47,757		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,980,670	0	8,980,670		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	47,870	0	47,870		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	18,986	0	18,986		194.01
194.02	07952	COMMUNITY HEALTH	38	0	38		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	2,003	0	2,003		194.04
194.05	07955	MARKETING	60,307	0	60,307		194.05
194.06	07956	GUEST MEALS	338	0	338		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	268,168	0	268,168		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	160,042	0	160,042		194.11
194.12	07962	TRINE STUDENT HEALTH	1,985	0	1,985		194.12
194.13	07963	OCCUPATIONAL HEALTH	41,195	0	41,195		194.13
194.14	07964	IMMUNIZATION CLINIC	8,103	0	8,103		194.14
194.15	07965	FOUNDATION	16,609	0	16,609		194.15
194.16	07967	RETAIL PHARMACY	32,673	0	32,673		194.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 2/25/2020 1:53 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	9,638,987	0	9,638,987		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	113,789					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		155,879				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	590	590	25,214,111			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,593	13,494	4,212,820	-11,808,775	50,997,446	5.00
7.00	00700	OPERATION OF PLANT	10,278	12,758	902,479	0	4,309,256	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,062	0	0	119,635	8.00
9.00	00900	HOUSEKEEPING	474	474	699,417	0	1,417,388	9.00
10.00	01000	DIETARY	4,272	4,272	111,417	0	539,124	10.00
11.00	01100	CAFETERIA	1,985	1,985	337,701	0	594,583	11.00
13.00	01300	NURSING ADMINISTRATION	706	1,794	774,141	0	1,127,900	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	3,116	191,683	0	576,504	14.00
15.00	01500	PHARMACY	1,155	1,155	506,730	0	3,367,938	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,107	499,859	0	738,385	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,265	16,265	2,537,262	0	4,930,636	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	1,180	79,161	0	228,192	31.00
43.00	04300	NURSERY	420	420	51,425	0	109,884	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,870	10,870	791,060	0	2,478,816	50.00
51.00	05100	RECOVERY ROOM	7,107	7,107	634,248	0	1,346,799	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,383	3,383	385,635	0	841,342	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,522	8,522	1,612,669	0	3,626,820	54.00
60.00	06000	LABORATORY	2,774	2,774	1,015,085	0	3,104,862	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	514	514	33,344	0	966,347	65.00
65.01	06501	SLEEP LAB	0	2,600	0	0	175,380	65.01
66.00	06600	PHYSICAL THERAPY	6,007	6,007	918,051	0	1,662,399	66.00
69.00	06900	ELECTROCARDIOLOGY	377	377	0	0	437,772	69.00
69.01	06901	CARDIAC REHAB	795	795	69,962	0	157,027	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	887,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,087,850	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	11,100	11,100	0	0	2,316,114	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,789	853,439	0	1,386,661	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	532	138,393	0	218,736	90.00
90.01	09001	CLINIC- MCDONALD	0	4,572	562,341	0	731,459	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0	2,504	1,442,483	0	730,639	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	0	1,767	220,874	0	349,640	90.04
91.00	09100	EMERGENCY	9,544	9,544	1,914,996	0	3,459,463	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,240	500,579	0	796,766	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,240	78,732	0	155,562	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,089	141,909	22,075,986	-11,808,775	44,977,348	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	580	0	0	43,046	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	529	0	0	15,003	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	2,240	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	500	0	34,923	194.04
194.05	07955	MARKETING	0	1,110	325,411	0	1,057,972	194.05
194.06	07956	GUEST MEALS	0	0	5,586	0	11,605	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	6,287	1,288,128	0	2,056,044	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	3,496	1,002,186	0	1,461,239	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	74,013	0	98,106	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	847	299,299	0	558,087	194.13
194.14	07964	IMMUNIZATION CLINIC	0	121	48,701	0	212,741	194.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.15	07965	FOUNDATION	120	120	94,301	0	380,699	194.15
194.16	07967	RETAIL PHARMACY	0	880	0	0	88,393	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,218,071	4,420,916	7,357,709		11,808,775	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	45.857429	28.361203	0.291809		0.231556	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			43,789		875,780	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001737		0.017173	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	129,037					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	72,341				8.00
9.00	00900	HOUSEKEEPING	474	16,337	6,397			9.00
10.00	01000	DIETARY	4,272	178	69	13,458		10.00
11.00	01100	CAFETERIA	1,985	549	212	0	24,420	11.00
13.00	01300	NURSING ADMINISTRATION	1,794	0	0	0	826	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	0	36	0	505	14.00
15.00	01500	PHARMACY	1,155	0	56	0	569	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,107	0	0	0	1,234	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,265	14,312	1,859	12,912	4,635	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	594	35	546	155	31.00
43.00	04300	NURSERY	420	4,404	541	0	68	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,870	5,611	484	0	1,302	50.00
51.00	05100	RECOVERY ROOM	7,107	3,669	316	0	965	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,383	1,285	138	0	507	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,522	6,533	446	0	2,377	54.00
60.00	06000	LABORATORY	2,774	316	243	0	2,135	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	514	12	69	0	29	65.00
65.01	06501	SLEEP LAB	2,600	766	62	0	0	65.01
66.00	06600	PHYSICAL THERAPY	6,007	1,502	243	0	1,475	66.00
69.00	06900	ELECTROCARDIOLOGY	377	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	795	0	0	0	117	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	11,100	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,789	757	199	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	532	0	0	0	251	90.00
90.01	09001	CLINIC- MCDONALD	4,572	591	232	0	768	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	2,504	494	194	0	1,003	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	1,767	0	0	0	183	90.04
91.00	09100	EMERGENCY	9,544	14,404	905	0	2,998	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,240	27	5	0	748	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,240	0	0	0	144	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,067	72,341	6,344	13,458	22,994	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	529	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	195	194.04
194.05	07955	MARKETING	1,110	0	0	0	300	194.05
194.06	07956	GUEST MEALS	0	0	0	0	18	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	6,287	0	53	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	3,496	0	0	0	913	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	847	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	121	0	0	0	0	194.14
194.15	07965	FOUNDATION	120	0	0	0	0	194.15
194.16	07967	RETAIL PHARMACY	880	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,307,090	191,015	1,808,225	859,636	875,278	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.128436	2.640481	282.667657	63.875464	35.842670	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	908,726	88,354	84,027	357,722	175,557	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.042368	1.221354	13.135376	26.580621	7.189066	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	226,320					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,885,041				14.00
15.00	01500	PHARMACY	0	17,796	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	279	0	561,675		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,417	118,125	0	4,223		30.00
31.00	03100	INTENSIVE CARE UNIT	3,223	4,628	0	346		31.00
43.00	04300	NURSERY	1,406	0	0	1,106		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,080	353,259	0	10,830		50.00
51.00	05100	RECOVERY ROOM	20,080	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,540	56,867	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,369	0	101,022		54.00
60.00	06000	LABORATORY	0	910,570	0	166,194		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	37,036	0	13,076		65.00
65.01	06501	SLEEP LAB	0	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	9,472	0	44,681		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,321	0	24,397		69.00
69.01	06901	CARDIAC REHAB	0	1,863	0	12,444		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	887,471	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,087,850	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0		76.00
76.01	03480	ONCOLOGY	0	1	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,371	0	35,286		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	5,211	19,702	0	17,799		90.00
90.01	09001	CLINIC- MCDONALD	0	7,652	0	13,580		90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0	14,826	0	29,205		90.02
90.03	09003	IV THERAPY	0	0	0	0		90.03
90.04	09004	OP PSYCH	0	613	0	2,259		90.04
91.00	09100	EMERGENCY	62,363	143,246	0	64,354		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,759	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	189	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	226,320	3,746,265	100	540,802		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0	0		194.04
194.05	07955	MARKETING	0	1,714	0	0		194.05
194.06	07956	GUEST MEALS	0	0	0	0		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0	0		194.08
194.09	07959	URGENT CARE	0	106,650	0	0		194.09
194.10	07960	RHC	0	0	0	0		194.10
194.11	07961	OBGYN	0	8,454	0	20,873		194.11
194.12	07962	TRINE STUDENT HEALTH	0	2,487	0	0		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	16,026	0	0		194.13
194.14	07964	IMMUNIZATION CLINIC	0	1,177	0	0		194.14
194.15	07965	FOUNDATION	0	2,268	0	0		194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0		194.16

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 1:53 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
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)	1,492,462	866,430	4,235,499	999,183		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.594477	0.223017	42,354.990000	1.778934		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	122,541	267,546	158,627	61,630		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.541450	0.068866	1,586.270000	0.109725		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,965,163		8,965,163	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	404,358		404,358	0	0	31.00
43.00	04300	NURSERY	330,831		330,831	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,974,788		3,974,788	0	0	50.00
51.00	05100	RECOVERY ROOM	2,216,974		2,216,974	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,318,058		1,318,058	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,237,483		5,237,483	0	0	54.00
60.00	06000	LABORATORY	4,582,667		4,582,667	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,263,346	0	1,263,346	0	0	65.00
65.01	06501	SLEEP LAB	342,472	0	342,472	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,501,515	0	2,501,515	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	598,788		598,788	0	0	69.00
69.01	06901	CARDIAC REHAB	252,831		252,831	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,290,889		1,290,889	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,582,358		1,582,358	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,235,499		4,235,499	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	3,308,950		3,308,950	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,110,529		2,110,529	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	370,684		370,684	0	0	90.00
90.01	09001	CLINIC- MCDONALD	1,209,404		1,209,404	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1,150,161		1,150,161	0	0	90.02
90.03	09003	IV THERAPY	0		0	0	0	90.03
90.04	09004	OP PSYCH	513,990		513,990	0	0	90.04
91.00	09100	EMERGENCY	5,612,034		5,612,034	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,125,769		2,125,769		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,061,839		1,061,839		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	247,785		247,785		0	116.00
200.00		Subtotal (see instructions)	56,809,165	0	56,809,165	0	0	200.00
201.00		Less Observation Beds	2,125,769		2,125,769		0	201.00
202.00		Total (see instructions)	54,683,396	0	54,683,396	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,099,218		8,099,218			30.00
31.00	03100	INTENSIVE CARE UNIT	342,500		342,500			31.00
43.00	04300	NURSERY	466,000		466,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,479,232	13,464,313	15,943,545	0.249304	0.000000	50.00
51.00	05100	RECOVERY ROOM	757,446	3,888,641	4,646,087	0.477170	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,115,992	410,536	1,526,528	0.863435	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,062,448	30,268,208	32,330,656	0.161997	0.000000	54.00
60.00	06000	LABORATORY	1,795,890	13,087,981	14,883,871	0.307895	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,698,292	1,018,463	2,716,755	0.465020	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,003,941	1,003,941	0.341128	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	657,732	3,492,611	4,150,343	0.602725	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	174,820	2,013,454	2,188,274	0.273635	0.000000	69.00
69.01	06901	CARDIAC REHAB	5,633	478,902	484,535	0.521801	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	532,884	2,240,401	2,773,285	0.465473	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	746,055	988,973	1,735,028	0.912007	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,726,132	11,093,940	12,820,072	0.330380	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	15,000	10,598,557	10,613,557	0.311766	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,758	1,092,462	1,102,220			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	602,199	602,199	0.615551	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	7,000	279,438	286,438	4.222219	0.000000	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	200	609,094	609,294	1.887695	0.000000	90.02
90.03	09003	IV THERAPY	0	0	0	0.000000	0.000000	90.03
90.04	09004	OP PSYCH	0	94,050	94,050	5.465072	0.000000	90.04
91.00	09100	EMERGENCY	547,591	16,835,373	17,382,964	0.322847	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	74,415	1,570,874	1,645,289	1.292034	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	604,415	604,415			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	270,700	270,700			116.00
200.00		Subtotal (see instructions)	23,314,238	116,007,526	139,321,764			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,314,238	116,007,526	139,321,764			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC- MCDONALD	0.000000		90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0.000000		90.02
90.03	09003	IV THERAPY	0.000000		90.03
90.04	09004	OP PSYCH	0.000000		90.04
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,965,163		8,965,163	0	8,965,163	30.00
31.00	03100	INTENSIVE CARE UNIT	404,358		404,358	0	404,358	31.00
43.00	04300	NURSERY	330,831		330,831	0	330,831	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,974,788		3,974,788	0	3,974,788	50.00
51.00	05100	RECOVERY ROOM	2,216,974		2,216,974	0	2,216,974	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,318,058		1,318,058	0	1,318,058	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,237,483		5,237,483	0	5,237,483	54.00
60.00	06000	LABORATORY	4,582,667		4,582,667	0	4,582,667	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,263,346	0	1,263,346	0	1,263,346	65.00
65.01	06501	SLEEP LAB	342,472	0	342,472	0	342,472	65.01
66.00	06600	PHYSICAL THERAPY	2,501,515	0	2,501,515	0	2,501,515	66.00
69.00	06900	ELECTROCARDIOLOGY	598,788		598,788	0	598,788	69.00
69.01	06901	CARDIAC REHAB	252,831		252,831	0	252,831	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,290,889		1,290,889	0	1,290,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,582,358		1,582,358	0	1,582,358	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,235,499		4,235,499	0	4,235,499	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	3,308,950		3,308,950	0	3,308,950	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,110,529		2,110,529	0	2,110,529	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	370,684		370,684	0	370,684	90.00
90.01	09001	CLINIC- MCDONALD	1,209,404		1,209,404	0	1,209,404	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1,150,161		1,150,161	0	1,150,161	90.02
90.03	09003	IV THERAPY	0		0	0	0	90.03
90.04	09004	OP PSYCH	513,990		513,990	0	513,990	90.04
91.00	09100	EMERGENCY	5,612,034		5,612,034	0	5,612,034	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,125,769		2,125,769		2,125,769	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,061,839		1,061,839		1,061,839	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	247,785		247,785		247,785	116.00
200.00		Subtotal (see instructions)	56,809,165	0	56,809,165	0	56,809,165	200.00
201.00		Less Observation Beds	2,125,769		2,125,769		2,125,769	201.00
202.00		Total (see instructions)	54,683,396	0	54,683,396	0	54,683,396	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,099,218		8,099,218			30.00
31.00	03100	INTENSIVE CARE UNIT	342,500		342,500			31.00
43.00	04300	NURSERY	466,000		466,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,479,232	13,464,313	15,943,545	0.249304	0.000000	50.00
51.00	05100	RECOVERY ROOM	757,446	3,888,641	4,646,087	0.477170	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,115,992	410,536	1,526,528	0.863435	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,062,448	30,268,208	32,330,656	0.161997	0.000000	54.00
60.00	06000	LABORATORY	1,795,890	13,087,981	14,883,871	0.307895	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,698,292	1,018,463	2,716,755	0.465020	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,003,941	1,003,941	0.341128	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	657,732	3,492,611	4,150,343	0.602725	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	174,820	2,013,454	2,188,274	0.273635	0.000000	69.00
69.01	06901	CARDIAC REHAB	5,633	478,902	484,535	0.521801	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	532,884	2,240,401	2,773,285	0.465473	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	746,055	988,973	1,735,028	0.912007	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,726,132	11,093,940	12,820,072	0.330380	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	15,000	10,598,557	10,613,557	0.311766	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,758	1,092,462	1,102,220	1.914798	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	602,199	602,199	0.615551	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	7,000	279,438	286,438	4.222219	0.000000	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	200	609,094	609,294	1.887695	0.000000	90.02
90.03	09003	IV THERAPY	0	0	0	0.000000	0.000000	90.03
90.04	09004	OP PSYCH	0	94,050	94,050	5.465072	0.000000	90.04
91.00	09100	EMERGENCY	547,591	16,835,373	17,382,964	0.322847	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	74,415	1,570,874	1,645,289	1.292034	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	604,415	604,415			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	270,700	270,700			116.00
200.00		Subtotal (see instructions)	23,314,238	116,007,526	139,321,764			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,314,238	116,007,526	139,321,764			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.249304		50.00
51.00	05100	RECOVERY ROOM	0.477170		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.863435		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161997		54.00
60.00	06000	LABORATORY	0.307895		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.465020		65.00
65.01	06501	SLEEP LAB	0.341128		65.01
66.00	06600	PHYSICAL THERAPY	0.602725		66.00
69.00	06900	ELECTROCARDIOLOGY	0.273635		69.00
69.01	06901	CARDIAC REHAB	0.521801		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.465473		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.912007		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330380		73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.311766		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.914798		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.615551		90.00
90.01	09001	CLINIC- MCDONALD	4.222219		90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1.887695		90.02
90.03	09003	IV THERAPY	0.000000		90.03
90.04	09004	OP PSYCH	5.465072		90.04
91.00	09100	EMERGENCY	0.322847		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.292034		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part II Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,974,788	989,999	2,984,789	0	0	50.00
51.00	05100	RECOVERY ROOM	2,216,974	628,194	1,588,780	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,318,058	306,674	1,011,384	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,237,483	803,344	4,434,139	0	0	54.00
60.00	06000	LABORATORY	4,582,667	380,372	4,202,295	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,263,346	63,537	1,199,809	0	0	65.00
65.01	06501	SLEEP LAB	342,472	96,811	245,661	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,501,515	539,464	1,962,051	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	598,788	41,059	557,729	0	0	69.00
69.01	06901	CARDIAC REHAB	252,831	69,756	183,075	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,290,889	76,358	1,214,531	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,582,358	93,595	1,488,763	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,235,499	158,627	4,076,872	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	3,308,950	941,771	2,367,179	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,110,529	273,844	1,836,685	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	370,684	30,766	339,918	0	0	90.00
90.01	09001	CLINIC- MCDONALD	1,209,404	186,710	1,022,694	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1,150,161	118,291	1,031,870	0	0	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	513,990	70,552	443,438	0	0	90.04
91.00	09100	EMERGENCY	5,612,034	940,014	4,672,020	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,125,769	448,152	1,677,617	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,061,839	64,327	997,512	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	247,785	47,757	200,028	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	47,108,813	7,369,974	39,738,839	0	0	200.00
201.00		Less Observation Beds	2,125,769	448,152	1,677,617	0	0	201.00
202.00		Total (line 200 minus line 201)	44,983,044	6,921,822	38,061,222	0	0	202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part II Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,974,788	15,943,545	0.249304		50.00
51.00	05100	RECOVERY ROOM	2,216,974	4,646,087	0.477170		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,318,058	1,526,528	0.863435		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,237,483	32,330,656	0.161997		54.00
60.00	06000	LABORATORY	4,582,667	14,883,871	0.307895		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	1,263,346	2,716,755	0.465020		65.00
65.01	06501	SLEEP LAB	342,472	1,003,941	0.341128		65.01
66.00	06600	PHYSICAL THERAPY	2,501,515	4,150,343	0.602725		66.00
69.00	06900	ELECTROCARDIOLOGY	598,788	2,188,274	0.273635		69.00
69.01	06901	CARDIAC REHAB	252,831	484,535	0.521801		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,290,889	2,773,285	0.465473		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,582,358	1,735,028	0.912007		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,235,499	12,820,072	0.330380		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000		76.00
76.01	03480	ONCOLOGY	3,308,950	10,613,557	0.311766		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,110,529	1,102,220	1.914798		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	370,684	602,199	0.615551		90.00
90.01	09001	CLINIC- MCDONALD	1,209,404	286,438	4.222219		90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1,150,161	609,294	1.887695		90.02
90.03	09003	IV THERAPY	0	0	0.000000		90.03
90.04	09004	OP PSYCH	513,990	94,050	5.465072		90.04
91.00	09100	EMERGENCY	5,612,034	17,382,964	0.322847		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,125,769	1,645,289	1.292034		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,061,839	604,415	1.756805		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	247,785	270,700	0.915349		116.00
200.00		Subtotal (sum of lines 50 thru 199)	47,108,813	130,414,046			200.00
201.00		Less Observation Beds	2,125,769	0			201.00
202.00		Total (line 200 minus line 201)	44,983,044	130,414,046			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part II Date/Time Prepared: 2/25/2020 1:53 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	989,999	15,943,545	0.062094	611,294	37,958	50.00
51.00	05100	RECOVERY ROOM	628,194	4,646,087	0.135209	147,532	19,948	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	306,674	1,526,528	0.200896	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,344	32,330,656	0.024848	521,396	12,956	54.00
60.00	06000	LABORATORY	380,372	14,883,871	0.025556	452,913	11,575	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	63,537	2,716,755	0.023387	431,017	10,080	65.00
65.01	06501	SLEEP LAB	96,811	1,003,941	0.096431	0	0	65.01
66.00	06600	PHYSICAL THERAPY	539,464	4,150,343	0.129981	105,724	13,742	66.00
69.00	06900	ELECTROCARDIOLOGY	41,059	2,188,274	0.018763	159,966	3,001	69.00
69.01	06901	CARDIAC REHAB	69,756	484,535	0.143965	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,358	2,773,285	0.027533	281,692	7,756	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93,595	1,735,028	0.053944	202,901	10,945	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,627	12,820,072	0.012373	400,433	4,955	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	941,771	10,613,557	0.088733	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	273,844	1,102,220	0.248448	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	30,766	602,199	0.051089	0	0	90.00
90.01	09001	CLINIC- MCDONALD	186,710	286,438	0.651834	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	118,291	609,294	0.194144	0	0	90.02
90.03	09003	IV THERAPY	0	0	0.000000	0	0	90.03
90.04	09004	OP PSYCH	70,552	94,050	0.750154	0	0	90.04
91.00	09100	EMERGENCY	940,014	17,382,964	0.054077	10,716	579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	448,152	1,645,289	0.272385	28,229	7,689	92.00
200.00		Total (lines 50 through 199)	7,257,890	129,538,931		3,353,813	141,184	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	0	0	0	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0	0	0	0	0	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	15,943,545	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,646,087	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,526,528	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,330,656	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	14,883,871	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,716,755	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,003,941	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,150,343	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,188,274	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	484,535	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,773,285	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,735,028	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,820,072	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	10,613,557	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,102,220	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	602,199	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	0	0	0	286,438	0.000000	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0	0	0	609,294	0.000000	90.02
90.03	09003	IV THERAPY	0	0	0	0	0.000000	90.03
90.04	09004	OP PSYCH	0	0	0	94,050	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	17,382,964	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,645,289	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	129,538,931		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/25/2020 1:53 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	611,294	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	147,532	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	521,396	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	452,913	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	431,017	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	105,724	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	159,966	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	281,692	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	202,901	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	400,433	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0.000000	0	0	0	0	90.02
90.03	09003	IV THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	OP PSYCH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	10,716	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	28,229	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,353,813	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/25/2020 1:53 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	0.249304	0	2,753,978	0	0	50.00
51.00	05100	RECOVERY ROOM	0.477170	0	534,325	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.863435	0	2,301	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161997	0	7,459,917	0	0	54.00
60.00	06000	LABORATORY	0.307895	0	3,184,305	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.465020	0	452,441	0	0	65.00
65.01	06501	SLEEP LAB	0.341128	0	4,161	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.602725	0	1,054,658	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.273635	0	571,992	0	0	69.00
69.01	06901	CARDIAC REHAB	0.521801	0	198,440	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.465473	0	330,240	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.912007	0	184,759	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330380	0	4,467,773	9,192	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.311766	0	3,127,934	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.615551	0	275,384	0	0	90.00
90.01	09001	CLINIC- MCDONALD	4.222219	0	55,615	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1.887695	0	39,317	0	0	90.02
90.03	09003	IV THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	OP PSYCH	5.465072	0	2,140	0	0	90.04
91.00	09100	EMERGENCY	0.322847	0	3,376,140	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.292034	0	848,852	2,089	0	92.00
200.00		Subtotal (see instructions)		0	28,924,672	11,281	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	28,924,672	11,281	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/25/2020 1:53 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	686,578	0		50.00
51.00	05100	RECOVERY ROOM	254,964	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,987	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,208,484	0		54.00
60.00	06000	LABORATORY	980,432	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	210,394	0		65.00
65.01	06501	SLEEP LAB	1,419	0		65.01
66.00	06600	PHYSICAL THERAPY	635,669	0		66.00
69.00	06900	ELECTROCARDIOLOGY	156,517	0		69.00
69.01	06901	CARDIAC REHAB	103,546	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	153,718	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	168,502	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,476,063	3,037		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	975,183	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	169,513	0		90.00
90.01	09001	CLINIC- MCDONALD	234,819	0		90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	74,219	0		90.02
90.03	09003	IV THERAPY	0	0		90.03
90.04	09004	OP PSYCH	11,695	0		90.04
91.00	09100	EMERGENCY	1,089,977	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,096,746	2,699		92.00
200.00		Subtotal (see instructions)	9,690,425	5,736		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,690,425	5,736		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/25/2020 1:53 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	0.249304	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.477170	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.863435	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161997	0	0	0	0	54.00
60.00	06000	LABORATORY	0.307895	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.465020	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.341128	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.602725	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.273635	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.521801	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.465473	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.912007	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330380	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.311766	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.615551	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	4.222219	0	0	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1.887695	0	0	0	0	90.02
90.03	09003	IV THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	OP PSYCH	5.465072	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.322847	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.292034	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V | Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC- MCDONALD	0	0		90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0	0		90.02
90.03	09003	IV THERAPY	0	0		90.03
90.04	09004	OP PSYCH	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part I Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,890,027	114,332	1,775,695	4,303	412.66	30.00
31.00	INTENSIVE CARE UNIT	118,859		118,859	136	873.96	31.00
43.00	NURSERY	49,962		49,962	468	106.76	43.00
200.00	Total (lines 30 through 199)	2,058,848		1,944,516	4,907		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	88	36,314	30.00
31.00	INTENSIVE CARE UNIT	13	11,361	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	101	47,675	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part II Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	989,999	15,943,545	0.062094	46,384	2,880	50.00
51.00	05100	RECOVERY ROOM	628,194	4,646,087	0.135209	14,171	1,916	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	306,674	1,526,528	0.200896	20,879	4,195	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,344	32,330,656	0.024848	38,586	959	54.00
60.00	06000	LABORATORY	380,372	14,883,871	0.025556	33,599	859	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	63,537	2,716,755	0.023387	31,773	743	65.00
65.01	06501	SLEEP LAB	96,811	1,003,941	0.096431	0	0	65.01
66.00	06600	PHYSICAL THERAPY	539,464	4,150,343	0.129981	12,305	1,599	66.00
69.00	06900	ELECTROCARDIOLOGY	41,059	2,188,274	0.018763	2,522	47	69.00
69.01	06901	CARDIAC REHAB	69,756	484,535	0.143965	105	15	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,358	2,773,285	0.027533	23,928	659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93,595	1,735,028	0.053944	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,627	12,820,072	0.012373	32,294	400	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	941,771	10,613,557	0.088733	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	273,844	1,102,220	0.248448	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	30,766	602,199	0.051089	0	0	90.00
90.01	09001	CLINIC- MCDONALD	186,710	286,438	0.651834	6,459	4,210	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	118,291	609,294	0.194144	163	32	90.02
90.03	09003	IV THERAPY	0	0	0.000000	0	0	90.03
90.04	09004	OP PSYCH	70,552	94,050	0.750154	0	0	90.04
91.00	09100	EMERGENCY	940,014	17,382,964	0.054077	10,245	554	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	448,152	1,645,289	0.272385	17,012	4,634	92.00
200.00		Total (lines 50 through 199)	7,257,890	129,538,931		290,425	23,702	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part III Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,303	0.00	88	30.00
31.00	03100	INTENSIVE CARE UNIT		0	136	0.00	13	31.00
43.00	04300	NURSERY		0	468	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	4,907		101	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	0	0	0	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0	0	0	0	0	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	15,943,545	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,646,087	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,526,528	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,330,656	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	14,883,871	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,716,755	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,003,941	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,150,343	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,188,274	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	484,535	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,773,285	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,735,028	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,820,072	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	10,613,557	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,102,220	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	602,199	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	0	0	0	286,438	0.000000	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0	0	0	609,294	0.000000	90.02
90.03	09003	IV THERAPY	0	0	0	0	0.000000	90.03
90.04	09004	OP PSYCH	0	0	0	94,050	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	17,382,964	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,645,289	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	129,538,931		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	46,384	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	14,171	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	20,879	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	38,586	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	33,599	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	31,773	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	12,305	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,522	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	105	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	23,928	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	32,294	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	0.000000	6,459	0	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	0.000000	163	0	0	0	90.02
90.03	09003	IV THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	OP PSYCH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	10,245	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	17,012	0	0	0	92.00
200.00		Total (lines 50 through 199)		290,425	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,864	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,303	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,217	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)	257	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)	304	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	889	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)	257	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	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,965,163	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)	39,259	25.00
26.00	Total swing-bed cost (see instructions)	542,321	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,422,842	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,422,842	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)	1,957.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,740,164	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)	1,740,164	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 1:53 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	404,358	136	2,973.22	43	127,848	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)	1,243,032	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,111,044	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)	503,062	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	503,062	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,086	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,957.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,125,769	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,890,027	8,965,163	0.210819	2,125,769	448,152	90.00
91.00	Nursing School cost	0	8,965,163	0.000000	2,125,769	0	91.00
92.00	Allied health cost	0	8,965,163	0.000000	2,125,769	0	92.00
93.00	All other Medical Education	0	8,965,163	0.000000	2,125,769	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,864	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,303	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,217	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)	257	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)	304	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	88	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)	468	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	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,965,163	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)	39,259	25.00
26.00	Total swing-bed cost (see instructions)	542,321	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,422,842	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,422,842	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)	1,957.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	172,254	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)	172,254	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	330,831	468	706.90	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	404,358	136	2,973.22	13	38,652	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	150,561	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	361,467	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)	47,675	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	23,702	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	71,377	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	290,090	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,086	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,957.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,125,769	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,890,027	8,965,163	0.210819	2,125,769	448,152	90.00
91.00	Nursing School cost	0	8,965,163	0.000000	2,125,769	0	91.00
92.00	Allied health cost	0	8,965,163	0.000000	2,125,769	0	92.00
93.00	All other Medical Education	0	8,965,163	0.000000	2,125,769	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,416,248		30.00
31.00	03100	INTENSIVE CARE UNIT		107,500		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.249304	611,294	152,398	50.00
51.00	05100	RECOVERY ROOM	0.477170	147,532	70,398	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.863435	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161997	521,396	84,465	54.00
60.00	06000	LABORATORY	0.307895	452,913	139,450	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.465020	431,017	200,432	65.00
65.01	06501	SLEEP LAB	0.341128	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.602725	105,724	63,722	66.00
69.00	06900	ELECTROCARDIOLOGY	0.273635	159,966	43,772	69.00
69.01	06901	CARDIAC REHAB	0.521801	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.465473	281,692	131,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.912007	202,901	185,047	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330380	400,433	132,295	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.311766	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.615551	0	0	90.00
90.01	09001	CLINIC- MCDONALD	4.222219	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1.887695	0	0	90.02
90.03	09003	IV THERAPY	0.000000	0	0	90.03
90.04	09004	OP PSYCH	5.465072	0	0	90.04
91.00	09100	EMERGENCY	0.322847	10,716	3,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.292034	28,229	36,473	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,353,813	1,243,032	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)		3,353,813		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 2/25/2020 1:53 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		1,197		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	0.249304	0	0	50.00
51.00	05100	RECOVERY ROOM	0.477170	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.863435	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161997	10,460	1,694	54.00
60.00	06000	LABORATORY	0.307895	16,881	5,198	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.465020	18,366	8,541	65.00
65.01	06501	SLEEP LAB	0.341128	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.602725	147,241	88,746	66.00
69.00	06900	ELECTROCARDIOLOGY	0.273635	3,821	1,046	69.00
69.01	06901	CARDIAC REHAB	0.521801	629	328	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.465473	15,198	7,074	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.912007	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330380	32,543	10,752	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.311766	13,155	4,101	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.615551	0	0	90.00
90.01	09001	CLINIC- MCDONALD	4.222219	0	0	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1.887695	0	0	90.02
90.03	09003	IV THERAPY	0.000000	0	0	90.03
90.04	09004	OP PSYCH	5.465072	0	0	90.04
91.00	09100	EMERGENCY	0.322847	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.292034	1,414	1,827	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		259,708	129,307	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)		259,708		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		109,028		30.00
31.00	03100	INTENSIVE CARE UNIT		6,408		31.00
43.00	04300	NURSERY		8,718		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.249304	46,384	11,564	50.00
51.00	05100	RECOVERY ROOM	0.477170	14,171	6,762	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.863435	20,879	18,028	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161997	38,586	6,251	54.00
60.00	06000	LABORATORY	0.307895	33,599	10,345	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.465020	31,773	14,775	65.00
65.01	06501	SLEEP LAB	0.341128	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.602725	12,305	7,417	66.00
69.00	06900	ELECTROCARDIOLOGY	0.273635	2,522	690	69.00
69.01	06901	CARDIAC REHAB	0.521801	105	55	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.465473	23,928	11,138	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.912007	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330380	32,294	10,669	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.311766	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.914798	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.615551	0	0	90.00
90.01	09001	CLINIC- MCDONALD	4.222219	6,459	27,271	90.01
90.02	09002	CLINIC - FAM PRAC, PEDS, & ENT	1.887695	163	308	90.02
90.03	09003	IV THERAPY	0.000000	0	0	90.03
90.04	09004	OP PSYCH	5.465072	0	0	90.04
91.00	09100	EMERGENCY	0.322847	10,245	3,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.292034	17,012	21,980	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		290,425	150,561	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)		290,425		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/25/2020 1:53 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,696,161	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)	9,696,161	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)	9,793,123	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)	72,084	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,114,708	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,606,331	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,606,331	30.00
31.00	Primary payer payments	2,894	31.00
32.00	Subtotal (line 30 minus line 31)	4,603,437	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)	656,379	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	426,646	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	483,395	36.00
37.00	Subtotal (see instructions)	5,030,083	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)	5,030,083	40.00
40.01	Sequestration adjustment (see instructions)	100,602	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,025,342	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-1,095,861	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-1 Part I Date/Time Prepared: 2/25/2020 1:53 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		2,559,614		6,025,342	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	04/23/2019	26,600		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		26,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,586,214		6,025,342	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		173,076		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,095,861	6.02
7.00	Total Medicare program liability (see instructions)		2,759,290		4,929,481	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2020 1:53 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		588,377		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		588,377		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		37,542		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		625,919		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/25/2020 1:53 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-2 | Date/Time Prepared: 2/25/2020 1:53 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)	508,093	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)	130,600	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	257	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)	638,693	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	638,693	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	638,693	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	638,693	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)	638,693	0	19.00
19.01	Sequestration adjustment (see instructions)	12,774	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	588,377	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)	37,542	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Prepared: 2/25/2020 1:53 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,111,044	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)	3,111,044	4.00
5.00	Primary payer payments	14,096	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,128,058	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)	3,128,058	19.00
20.00	Deductibles (exclude professional component)	334,080	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,793,978	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,793,978	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	33,268	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	21,624	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	5,553	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,815,602	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)	2,815,602	30.00
30.01	Sequestration adjustment (see instructions)	56,312	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,586,214	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)	173,076	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-3 Part VII Date/Time Prepared: 2/25/2020 1:53 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	124,154		8.00
9.00	Ancillary service charges	290,425	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)	414,579	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)	414,579	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	414,579	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	237,141	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-237,141	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G | Date/Time Prepared: 2/25/2020 1:53 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	2,711,733	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,573,255	0	0	0	4.00
5.00	Other receivable	301,909	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,746,838	0	0	0	7.00
8.00	Prepaid expenses	810,199	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,143,934	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,419,368	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	58,040,916	0	0	0	15.00
16.00	Accumulated depreciation	-20,879,411	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	20,000,166	0	0	0	23.00
24.00	Accumulated depreciation	-15,213,111	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)	43,367,928	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	23,802,765	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	957,171	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,759,936	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	83,271,798	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,209,732	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,335,033	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	846,968	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	199,833	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,591,566	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	42,789,953	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	42,789,953	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	48,381,519	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	34,890,279				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)	34,890,279	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	83,271,798	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-1 | Date/Time Prepared: 2/25/2020 1:53 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		38,549,829		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,659,550				2.00
3.00	Total (sum of line 1 and line 2)		34,890,279		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)		34,890,279		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)		34,890,279		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2020 1:53 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,565,218		8,565,218	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,565,218		8,565,218	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	342,500		342,500	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)	342,500		342,500	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,907,718		8,907,718	17.00
18.00	Ancillary services	13,767,555	94,048,920	107,816,475	18.00
19.00	Outpatient services	629,206	19,991,028	20,620,234	19.00
20.00	RURAL HEALTH CLINIC	9,758	1,092,462	1,102,220	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		604,415	604,415	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	270,700	270,700	26.00
27.00	HOSPITALIST FEES	-317	656	339	27.00
27.01	OTHER REVENUE	479,738	6,360,147	6,839,885	27.01
27.02	PROFESSIONAL FEES	353,934	1,713,699	2,067,633	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,147,592	124,082,027	148,229,619	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,648,355		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)		70,648,355		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-3 | Date/Time Prepared: 2/25/2020 1:53 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	148,229,619	1.00
2.00	Less contractual allowances and discounts on patients' accounts	82,167,059	2.00
3.00	Net patient revenues (line 1 minus line 2)	66,062,560	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	70,648,355	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,585,795	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	642,465	24.00
24.01	CONTRIBUTIONS	161,439	24.01
24.02	LOSS ON DISPOSAL OF PROPERTY	-345	24.02
24.03	CONTRIBUTION TO FOUNDATION	0	24.03
24.04	CHANGE IN ASSETS FOUNDATION	0	24.04
24.05	INVESTMENT INCOME	122,686	24.05
24.06	OP REVENUE, GROUPED IN OTHER	0	24.06
25.00	Total other income (sum of lines 6-24)	926,245	25.00
26.00	Total (line 5 plus line 25)	-3,659,550	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)	-3,659,550	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H | Date/Time Prepared: 2/25/2020 1:53 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	213,366	0	0	71,969	26,046	311,381	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	156,007	0	16,932	0	0	172,939	6.00
7.00	Physical Therapy	134,195	0	0	0	0	134,195	7.00
8.00	Occupational Therapy	23,270	0	0	0	0	23,270	8.00
9.00	Speech Pathology	110	0	0	0	0	110	9.00
10.00	Medical Social Services	32,504	0	0	0	0	32,504	10.00
11.00	Home Health Aide	41,915	0	0	0	0	41,915	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)	601,367	0	16,932	71,969	26,046	716,314	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	-84,527	226,854	0	226,854			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	-12,911	160,028	0	160,028			6.00
7.00	Physical Therapy	-641	133,554	0	133,554			7.00
8.00	Occupational Therapy	0	23,270	0	23,270			8.00
9.00	Speech Pathology	0	110	0	110			9.00
10.00	Medical Social Services	0	32,504	0	32,504			10.00
11.00	Home Health Aide	-2,710	39,205	0	39,205			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)	-100,789	615,525	0	615,525			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-1 Part I | Date/Time Prepared: 2/25/2020 1:53 pm

Home Health Agency I | PPS

			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	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	226,854	0	0	0	0	226,854	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	160,028	0	0	0	0	160,028	6.00
7.00	Physical Therapy	133,554	0	0	0	0	133,554	7.00
8.00	Occupational Therapy	23,270	0	0	0	0	23,270	8.00
9.00	Speech Pathology	110	0	0	0	0	110	9.00
10.00	Medical Social Services	32,504	0	0	0	0	32,504	10.00
11.00	Home Health Aide	39,205	0	0	0	0	39,205	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)	615,525	0	0	0	0	615,525	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	226,854			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	93,403	253,431		6.00
7.00	Physical Therapy	77,951	211,505		7.00
8.00	Occupational Therapy	13,582	36,852		8.00
9.00	Speech Pathology	64	174		9.00
10.00	Medical Social Services	18,971	51,475		10.00
11.00	Home Health Aide	22,883	62,088		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)		615,525		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-1 Part II | Date/Time Prepared: 2/25/2020 1:53 pm

Home Health Agency I | PPS

		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	-226,854	388,671	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	160,028	6.00
7.00	Physical Therapy	0	0	0	0	0	133,554	7.00
8.00	Occupational Therapy	0	0	0	0	0	23,270	8.00
9.00	Speech Pathology	0	0	0	0	0	110	9.00
10.00	Medical Social Services	0	0	0	0	0	32,504	10.00
11.00	Home Health Aide	0	0	0	0	0	39,205	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	-226,854	388,671	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		226,854	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.583666	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

Period: From 10/01/2018 To 09/30/2019

Worksheet H-2 Part I Date/Time Prepared: 2/25/2020 1:53 pm

Home Health Agency I

PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	35,168	146,073	181,241	41,967	1.00
2.00	Skilled Nursing Care	253,431	0	0	0	253,431	58,685	2.00
3.00	Physical Therapy	211,505	0	0	0	211,505	48,975	3.00
4.00	Occupational Therapy	36,852	0	0	0	36,852	8,533	4.00
5.00	Speech Pathology	174	0	0	0	174	40	5.00
6.00	Medical Social Services	51,475	0	0	0	51,475	11,919	6.00
7.00	Home Health Aide	62,088	0	0	0	62,088	14,377	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)	615,525	0	35,168	146,073	796,766	184,496	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	50,999	71	1,413	0	26,810	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)	50,999	71	1,413	0	26,810	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-2 Part I | Date/Time Prepared: 2/25/2020 1:53 pm

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	1,284	0	0	303,785	0	303,785	1.00
2.00	Skilled Nursing Care	0	0	0	312,116	0	312,116	2.00
3.00	Physical Therapy	0	0	0	260,480	0	260,480	3.00
4.00	Occupational Therapy	0	0	0	45,385	0	45,385	4.00
5.00	Speech Pathology	0	0	0	214	0	214	5.00
6.00	Medical Social Services	0	0	0	63,394	0	63,394	6.00
7.00	Home Health Aide	0	0	0	76,465	0	76,465	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,284	0	0	1,061,839	0	1,061,839	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	125,077	437,193					2.00
3.00	Physical Therapy	104,386	364,866					3.00
4.00	Occupational Therapy	18,188	63,573					4.00
5.00	Speech Pathology	86	300					5.00
6.00	Medical Social Services	25,405	88,799					6.00
7.00	Home Health Aide	30,643	107,108					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	303,785	1,061,839					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.	0.400743						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period: From 10/01/2018 To 09/30/2019

Worksheet H-2 Part II Date/Time Prepared: 2/25/2020 1:53 pm

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	1,240	500,579	0	181,241	1,240	1.00
2.00	Skilled Nursing Care	0	0	0	0	253,431	0	2.00
3.00	Physical Therapy	0	0	0	0	211,505	0	3.00
4.00	Occupational Therapy	0	0	0	0	36,852	0	4.00
5.00	Speech Pathology	0	0	0	0	174	0	5.00
6.00	Medical Social Services	0	0	0	0	51,475	0	6.00
7.00	Home Health Aide	0	0	0	0	62,088	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,240	500,579		796,766	1,240	20.00
21.00	Total cost to be allocated	0	35,168	146,073		184,496	50,999	21.00
22.00	Unit cost multiplier	0.000000	28.361290	0.291808		0.231556	41.128226	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	27	5	0	748	0	5,759	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)	27	5	0	748	0	5,759	20.00
21.00	Total cost to be allocated	71	1,413	0	26,810	0	1,284	21.00
22.00	Unit cost multiplier	2.629630	282.600000	0.000000	35.842246	0.000000	0.222955	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period: From 10/01/2018 To 09/30/2019

Worksheet H-2 Part II
Date/Time Prepared: 2/25/2020 1:53 pm

Home Health Agency I

PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-3 Part I | Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII | Home Health Agency I | PPS

	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	437,193		437,193	1,399	312.50	1.00
2.00	Physical Therapy	3.00	364,866	0	364,866	1,253	291.19	2.00
3.00	Occupational Therapy	4.00	63,573	0	63,573	180	353.18	3.00
4.00	Speech Pathology	5.00	300	0	300	5	60.00	4.00
5.00	Medical Social Services	6.00	88,799		88,799	37	2,399.97	5.00
6.00	Home Health Aide	7.00	107,108		107,108	633	169.21	6.00
7.00	Total (sum of lines 1-6)		1,061,839	0	1,061,839	3,507		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	462			8.00
9.00	Physical Therapy		99915	0	466			9.00
10.00	Occupational Therapy		99915	0	67			10.00
11.00	Speech Pathology		99915	0	4			11.00
12.00	Medical Social Services		99915	0	18			12.00
13.00	Home Health Aide		99915	0	171			13.00
14.00	Total (sum of lines 8-13)			0	1,188			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	462		0	144,375		1.00
2.00	Physical Therapy	0	466		0	135,695		2.00
3.00	Occupational Therapy	0	67		0	23,663		3.00
4.00	Speech Pathology	0	4		0	240		4.00
5.00	Medical Social Services	0	18		0	43,199		5.00
6.00	Home Health Aide	0	171		0	28,935		6.00
7.00	Total (sum of lines 1-6)	0	1,188		0	376,107		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1315 HHA CCN: 15-7117 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-3 Part I Date/Time Prepared: 2/25/2020 1:53 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	144,375		1.00
2.00	Physical Therapy	135,695		2.00
3.00	Occupational Therapy	23,663		3.00
4.00	Speech Pathology	240		4.00
5.00	Medical Social Services	43,199		5.00
6.00	Home Health Aide	28,935		6.00
7.00	Total (sum of lines 1-6)	376,107		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

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

Period:
From 10/01/2018
To 09/30/2019

Worksheet H-3
Part II
Date/Time Prepared:
2/25/2020 1:53 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	0.602725	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.465473	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.330380	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/25/2020 1:53 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	178,998	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	9,975	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,571	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	4,044	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	3,459	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	203,047	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	203,047	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	203,047	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	203,047	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	203,047	31.00
31.01	Sequestration adjustment (see instructions)	0	4,060	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	198,987	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-5 | Date/Time Prepared: 2/25/2020 1:53 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		198,987	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		198,987	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		198,987	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O | Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	126	923	1,049	22,292	23,341	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	13,672	13,672	0	13,672	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	40,578	0	40,578	0	40,578	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	641	0	641	0	641	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	10,022	0	10,022	0	10,022	33.00
34.00	SPIRITUAL COUNSELING**	2,491	0	2,491	0	2,491	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	2,710	0	2,710	0	2,710	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	3,964	3,964	0	3,964	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	56,568	18,559	75,127	22,292	97,419	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O | Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	23,341		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	13,672		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	40,578		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	641		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	10,022		33.00
34.00	SPIRITUAL COUNSELING**	0	2,491		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	2,710		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	3,964		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	97,419		100.00

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

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

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

Period: From 10/01/2018 To 09/30/2019

Worksheet O-1

Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

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

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

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

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

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

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

Period: From 10/01/2018 To 09/30/2019

Worksheet O-2

Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	40,578	0	40,578	0	40,578	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	641	0	641	0	641	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	10,022	0	10,022	0	10,022	33.00
34.00	SPIRITUAL COUNSELING	2,491	0	2,491	0	2,491	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	2,710	0	2,710	0	2,710	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	3,964	3,964	0	3,964	46.00
100.00	TOTAL *	56,442	3,964	60,406	0	60,406	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	40,578		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	641		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	10,022		33.00
34.00	SPIRITUAL COUNSELING	0	2,491		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	2,710		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	3,964		46.00
100.00	TOTAL *	0	60,406		100.00

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

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-3 | Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

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

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

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

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

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

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

Period: From 10/01/2018 To 09/30/2019

Worksheet O-4

Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

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

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

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

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

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

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

Period: From 10/01/2018 To 09/30/2019

Worksheet O-5

Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	35,168	35,168	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	22,975	22,975	3.00
4.00	ADMINISTRATIVE & GENERAL	23,341	92,181	115,522	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	42	42	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	13,672		13,672	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	60,406		60,406	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	97,419	150,366	247,785	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-6 Part I | Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,168		35,168			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	22,975	0	35,168	58,143		3.00
4.00	ADMINISTRATIVE & GENERAL	115,522	0	0	0	115,522	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	42	0	0	0	42	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	13,672	0	0	0	13,672	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	60,406			58,143	118,549	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	247,785	0	35,168	58,143	247,785	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

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

Period: From 10/01/2018 To 09/30/2019

Worksheet O-6 Part I
Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	115,522					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	37	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	11,941	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	103,544					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	115,522	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-6 Part I | Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	79				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			25,613		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	79	0	25,613	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	79	0	25,613	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

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

Period: From 10/01/2018 To 09/30/2019

Worksheet O-6 Part I
Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		247,785	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	247,785	100.00

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

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

Period:
From 10/01/2018
To 09/30/2019

Worksheet O-6
Part II
Date/Time Prepared:
2/25/2020 1:53 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		34,646				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	34,646	33,934			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-115,522	132,263	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	42	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	13,672	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			33,934	0	118,549	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	35,168	58,143		115,522	100.00
101.00	UNIT COST MULTIPLIER	0.000000	1.015067	1.713414		0.873426	101.00

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

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

Period:
From 10/01/2018
To 09/30/2019

Worksheet O-6
Part II
Date/Time Prepared:
2/25/2020 1:53 pm

Hospice I

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

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

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

Period:
From 10/01/2018
To 09/30/2019

Worksheet O-6
Part II
Date/Time Prepared:
2/25/2020 1:53 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,764					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			45,387			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,764	0	45,387	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	79	0	25,613	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.044785	0.000000	0.564325	0.000000	0.000000	101.00

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

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

Period: From 10/01/2018 To 09/30/2019

Worksheet O-6
Part II
Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

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

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

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

Period: From 10/01/2018 To 09/30/2019

Worksheet O-7

Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.602725	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.330380	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.307895	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.465473	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CHEMICAL DEPENDENCY	76.00	0.000000	0	0	0	10.00
10.01	ONCOLOGY	76.01	0.311766	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2018 To 09/30/2019 | Worksheet O-8 | Date/Time Prepared: 2/25/2020 1:53 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			247,785	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			1,764	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			140.47	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	1,412	0		9.00
10.00	Program cost (line 8 times line 9)	198,344	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			0	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			247,785	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			1,764	22.00
23.00	Average cost per diem (line 21 divided by line 22)			140.47	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2018 To 09/30/2019 | Worksheet M-1 | Date/Time Prepared: 2/25/2020 1:53 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	421,465	7,364	428,829	0	428,829	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	154,484	0	154,484	0	154,484	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	176,363	0	176,363	0	176,363	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	2,836	0	2,836	0	2,836	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	755,148	7,364	762,512	0	762,512	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	6,385	6,385	0	6,385	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	6,385	6,385	0	6,385	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	755,148	13,749	768,897	0	768,897	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	35,246	35,246	0	35,246	29.00
30.00	Administrative Costs	98,291	42,642	140,933	0	140,933	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	98,291	77,888	176,179	0	176,179	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	853,439	91,637	945,076	0	945,076	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2018 To 09/30/2019 | Worksheet M-1 | Date/Time Prepared: 2/25/2020 1:53 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	428,829		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	154,484		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	176,363		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	2,836		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	762,512		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	6,385		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	6,385		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	768,897		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	35,246		29.00
30.00	Administrative Costs	0	140,933		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	176,179		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	945,076		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2018 To 09/30/2019 | Worksheet M-2 | Date/Time Prepared: 2/25/2020 1:53 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.89	3,648	4,200	3,738		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.18	4,707	2,100	2,478		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.07	8,355		6,216	8,355	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)	2.07	8,355			8,355	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)					768,897	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)					768,897	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)					176,179	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,165,453	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,341,632	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,341,632	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,341,632	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,110,529	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/25/2020 1:53 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)		2,110,529	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		17,262	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,093,267	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,355	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		8,355	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		250.54	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	250.54	250.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,283	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	321,443	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	321,443	16.00
16.01	Total program charges (see instructions)(from contractor's records)		166,557	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,362	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		16,138	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.)		225,535	16.04
16.05	Total program cost (see instructions)	0	241,673	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		23,386	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		26,961	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		241,673	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,816	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		253,489	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)		253,489	26.00
26.01	Sequestration adjustment (see instructions)		5,070	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		176,770	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)		71,649	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/25/2020 1:53 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)	762,512	762,512	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.004123	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	3,144	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	3,145	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	6,289	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	768,897	768,897	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,341,632	1,341,632	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.008179	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	10,973	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	17,262	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	187	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	92.31	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	128	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	11,816	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)		17,262	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		11,816	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/25/2020 1:53 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		176,770	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)		176,770	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		71,649	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		248,419	7.00

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