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: 15-1319	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/25/2020 4:21 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/25/2020 Time: 4:21 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GIBSON GENERAL HOSPITAL (15-1319) for the cost reporting period beginning 10/01/2018 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	-129,652	-54,115	0	20,575	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	-298,659	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		5,841		0	10.00
200.00	Total	0	-428,311	-48,273	0	20,575	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 4:21 pm

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

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

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2018	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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2020 4:21 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	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2020 4:21 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 4:21 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: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2020 4:21 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: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 4:21 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	60,536	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 4:21 pm

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	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: 15-1319	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/25/2020 4:21 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2020 4:21 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/03/2020	Y	01/03/2020	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2020 4:21 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1319	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/25/2020 4:21 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.	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: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2020 4:21 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,300	21,120.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		20	7,300	21,120.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	2,112.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	23,232.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2020 4:21 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)	513	15	880			1.00
2.00	HMO and other (see instructions)	195	49				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	1,417	0	1,417			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	733			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,930	15	3,030			7.00
8.00	INTENSIVE CARE UNIT	23	0	88			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,953	15	3,118	0.00	237.29	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,864	35	4,926	0.00	6.63	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	167	0	537	0.00	2.94	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	246.86	27.00
28.00	Observation Bed Days		0	633			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2020 4:21 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	181	6	284	1.00
2.00	HMO and other (see instructions)			48	20		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	181	6	284	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-4 | Date/Time Prepared: 2/25/2020 4:21 pm

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	107.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.12	0.00	1.12	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			3.56	0.00	3.56	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.76	0.00	0.76	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.15	0.00	0.15	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.04	0.00	0.04	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.00	0.00	1.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,310	114	39	12	1,475	21.00
22.00	Skilled Nursing Visit Charges	209,232	18,240	6,179	1,920	235,571	22.00
23.00	Physical Therapy Visits	921	10	8	7	946	23.00
24.00	Physical Therapy Visit Charges	188,805	2,050	1,640	1,435	193,930	24.00
25.00	Occupational Therapy Visits	175	1	1	3	180	25.00
26.00	Occupational Therapy Visit Charges	35,875	205	205	615	36,900	26.00
27.00	Speech Pathology Visits	23	0	0	0	23	27.00
28.00	Speech Pathology Visit Charges	4,715	0	0	0	4,715	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	221	13	0	6	240	31.00
32.00	Home Health Aide Visit Charges	16,572	975	0	450	17,997	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,650	138	48	28	2,864	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	455,199	21,470	8,024	4,420	489,113	35.00
36.00	Total Number of Episodes (standard/non outlier)	141		20	3	164	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	23,607	5,779	476	0	29,862	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-8 | Date/Time Prepared: 2/25/2020 4:21 pm

RHC I | Cost

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

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

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

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

Worksheet S-8

Date/Time Prepared:
2/25/2020 4:21 pm

RHC I

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet S-10 | Date/Time Prepared: 2/25/2020 4:21 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)		0.475575	1.00
	Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid		2,680,236	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		7,557,100	6.00
7.00	Medicaid cost (line 1 times line 6)		3,593,968	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)		913,732	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)		913,732	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)	128,075	0	128,075	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	60,909	0	60,909	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)	60,909	0	60,909	23.00

			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,874,185	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		230,262	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		354,250	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,519,935	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,322,406	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,383,315	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,297,047	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 2/25/2020 4:21 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,299,906	1,299,906	265,560	1,565,466	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	209,379	848,969	1,058,348	-426,722	631,626	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,441,659	4,270,152	5,711,811	268,485	5,980,296	5.00
7.00	00700	OPERATION OF PLANT	217,635	914,748	1,132,383	197,349	1,329,732	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,699	37,517	83,216	5,234	88,450	8.00
9.00	00900	HOUSEKEEPING	273,143	108,015	381,158	16,579	397,737	9.00
10.00	01000	DIETARY	427,141	373,718	800,859	-427,030	373,829	10.00
11.00	01100	CAFETERIA	0	0	0	461,135	461,135	11.00
13.00	01300	NURSING ADMINISTRATION	42,532	-7,075	35,457	-674	34,783	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	177,028	129,022	306,050	10,333	316,383	14.00
15.00	01500	PHARMACY	138,162	462,292	600,454	5,775	606,229	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	266,192	119,145	385,337	12,749	398,086	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,426,220	1,079,618	2,505,838	-25,533	2,480,305	30.00
31.00	03100	INTENSIVE CARE UNIT	6,378	1,065	7,443	-27	7,416	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	831,831	845,942	1,677,773	-152,134	1,525,639	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	695,556	765,230	1,460,786	21,123	1,481,909	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	155,980	155,980	0	155,980	54.03
60.00	06000	LABORATORY	795,254	903,953	1,699,207	23,611	1,722,818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	45,637	45,637	0	45,637	62.00
65.00	06500	RESPIRATORY THERAPY	419,746	437,342	857,088	6,874	863,962	65.00
66.00	06600	PHYSICAL THERAPY	664,442	276,094	940,536	20,936	961,472	66.00
67.00	06700	OCCUPATIONAL THERAPY	250,479	42,196	292,675	4,063	296,738	67.00
68.00	06800	SPEECH PATHOLOGY	91,328	11,999	103,327	0	103,327	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	148,295	148,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	553,194	553,194	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,068,408	1,068,408	0	1,068,408	73.00
76.00	03480	INFUSION THERAPY	81,343	66,137	147,480	1,415	148,895	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	191,410	112,995	304,405	-11,706	292,699	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	3,775	3,775	-1,815	1,960	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	205,431	391,161	596,592	-211,907	384,685	90.03
91.00	09100	EMERGENCY	804,383	1,598,236	2,402,619	11,023	2,413,642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	413,774	206,907	620,681	18,880	639,561	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		266,159	266,159	-266,159	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,116,145	16,835,243	26,951,388	528,906	27,480,294	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	2,931,482	1,841,196	4,772,678	-545,775	4,226,903	194.00
194.01	07951	FOUNDATION	52,619	4,379	56,998	0	56,998	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	907,577	426,460	1,334,037	16,869	1,350,906	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	14,007,823	19,107,278	33,115,101	0	33,115,101	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A | Date/Time Prepared: 2/25/2020 4:21 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	-115,553	1,449,913		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,211,985	1,843,611		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,088,273	7,068,569		5.00
7.00	00700	OPERATION OF PLANT	473,803	1,803,535		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,450		8.00
9.00	00900	HOUSEKEEPING	190,412	588,149		9.00
10.00	01000	DIETARY	104,677	478,506		10.00
11.00	01100	CAFETERIA	-145,585	315,550		11.00
13.00	01300	NURSING ADMINISTRATION	177,744	212,527		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	316,383		14.00
15.00	01500	PHARMACY	323,733	929,962		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,874	477,960		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-393,018	2,087,287		30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,416		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-661,893	863,746		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,481,909		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	155,980		54.03
60.00	06000	LABORATORY	0	1,722,818		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	45,637		62.00
65.00	06500	RESPIRATORY THERAPY	-81,201	782,761		65.00
66.00	06600	PHYSICAL THERAPY	0	961,472		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	296,738		67.00
68.00	06800	SPEECH PATHOLOGY	0	103,327		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	148,295		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	553,194		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-11,195	1,057,213		73.00
76.00	03480	INFUSION THERAPY	-23,052	125,843		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	292,699		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	0	1,960		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	384,685		90.03
91.00	09100	EMERGENCY	0	2,413,642		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	639,561		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,219,004	29,699,298		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	4,226,903		194.00
194.01	07951	FOUNDATION	0	56,998		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	1,350,906		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	2,219,004	35,334,105		200.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/25/2020 4:21 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	245,948	215,187	1.00
	0		245,948	215,187	
	D - MED SUPPLY CHG PTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	148,295	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	553,194	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	701,489	
	F - BUSINESS HEALTH SER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	86,472	32,630	1.00
	0		86,472	32,630	
	G - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	265,560	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	599	2.00
	0		0	266,159	
	I - QUALITY SERVICES				
1.00	ADMINISTRATIVE & GENERAL	5.00	67,012	28,935	1.00
	0		67,012	28,935	
	J - HEALTH INSURANCE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	81,966	1.00
2.00	OPERATION OF PLANT	7.00	0	7,505	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	5,234	3.00
4.00	HOUSEKEEPING	9.00	0	16,579	4.00
5.00	DIETARY	10.00	0	34,105	5.00
6.00	NURSING ADMINISTRATION	13.00	0	987	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	12,749	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	72,532	8.00
9.00	OPERATING ROOM	50.00	0	27,339	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,123	10.00
11.00	LABORATORY	60.00	0	23,611	11.00
12.00	RESPIRATORY THERAPY	65.00	0	15,870	12.00
13.00	PHYSICAL THERAPY	66.00	0	30,374	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	4,128	14.00
15.00	CENTRAL SERVICE & SUPPLY	14.00	0	10,474	15.00
16.00	PHARMACY	15.00	0	5,846	16.00
17.00	INFUSION THERAPY	76.00	0	2,474	17.00
18.00	RURAL HEALTH CLINIC	88.00	0	6,220	18.00
19.00	PAIN MANAGEMENT	90.03	0	5,829	19.00
20.00	EMERGENCY	91.00	0	19,704	20.00
21.00	HOME HEALTH AGENCY	101.00	0	19,069	21.00
22.00	MOB	194.00	0	97,242	22.00
23.00	SNF - PERRY CO.	194.03	0	43,162	23.00
	0		0	564,122	
	K - WELLNESS CENTER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	265	18,033	1.00
	0		265	18,033	
	M - SNF OPERATION OF PLANT				
1.00	OPERATION OF PLANT	7.00	23,157	0	1.00
	0		23,157	0	
	N - MALPRACTICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,543	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	46,543	
	O - MOB COLLECTION EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,577	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/25/2020 4:21 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	0		0	3,577		
	Q - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	166,687		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	0		0	166,687		
	R - HRS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	95,140		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	95,140		
500.00	Grand Total: Increases		422,854	2,138,502		500.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/25/2020 4:21 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	C - CAFETERIA						
1.00	DIETARY	10.00	245,948	215,187	0		1.00
	0		245,948	215,187			
	D - MED SUPPLY CHG PTS						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	141	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,118	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	27	0		3.00
4.00	OPERATING ROOM	50.00	0	127,858	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	8,996	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	922	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	65	0		7.00
8.00	PHARMACY	15.00	0	71	0		8.00
9.00	INFUSION THERAPY	76.00	0	1,059	0		9.00
10.00	RURAL HEALTH CLINIC	88.00	0	9,955	0		10.00
11.00	PAIN MANAGEMENT	90.03	0	216,938	0		11.00
12.00	EMERGENCY	91.00	0	8,681	0		12.00
13.00	HOME HEALTH AGENCY	101.00	0	189	0		13.00
14.00	MOB	194.00	0	324,391	0		14.00
15.00	SNF - PERRY CO.	194.03	0	78	0		15.00
	0		0	701,489			
	F - BUSINESS HEALTH SER						
1.00	MOB	194.00	86,472	32,630	0		1.00
	0		86,472	32,630			
	G - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	266,159	10		1.00
2.00		0.00	0	0	0		2.00
	0		0	266,159			
	I - QUALITY SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	67,012	28,935	0		1.00
	0		67,012	28,935			
	J - HEALTH INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	564,122	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
	0		0	564,122			
	K - WELLNESS CENTER						
1.00	MOB	194.00	265	18,033	0		1.00
	0		265	18,033			
	M - SNF OPERATION OF PLANT						
1.00	SNF - PERRY CO.	194.03	23,157	0	0		1.00
	0		23,157	0			
	N - MALPRACTICE						
1.00	OPERATING ROOM	50.00	0	7,451	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	1,588	0		2.00
3.00	PAIN MANAGEMENT	90.03	0	574	0		3.00
4.00	MOB	194.00	0	33,872	0		4.00
5.00	SNF - PERRY CO.	194.03	0	3,058	0		5.00
	0		0	46,543			
	O - MOB COLLECTION EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	20	0		1.00
2.00	MOB	194.00	0	3,281	0		2.00
3.00	OPERATING ROOM	50.00	0	276	0		3.00
	0		0	3,577			

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-6 | Date/Time Prepared: 2/25/2020 4:21 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	Q - UTILITIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	55,287	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	1,661	0		2.00
3.00	OPERATING ROOM	50.00	0	42,786	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	8,516	0		4.00
5.00	DIABETES	90.01	0	1,815	0		5.00
6.00	MOB	194.00	0	56,622	0		6.00
	0		0	166,687			
	R - HRS RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	0	6,363	0		1.00
2.00	PAIN MANAGEMENT	90.03	0	224	0		2.00
3.00	MOB	194.00	0	87,451	0		3.00
4.00	OPERATING ROOM	50.00	0	1,102	0		4.00
	TOTALS		0	95,140			
500.00	Grand Total: Decreases		422,854	2,138,502			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2020 4:21 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	680,034	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,707,979	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	13,638,960	3,731,561	0	3,731,561	9,546	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,026,973	3,731,561	0	3,731,561	9,546	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	34,026,973	3,731,561	0	3,731,561	9,546	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	680,034	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	19,707,979	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	17,360,975	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,748,988	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	37,748,988	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2020 4:21 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,128,154	0	0	152,917	18,835	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,128,154	0	0	152,917	18,835	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,299,906	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,299,906	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2020 4:21 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	37,748,988	0	37,748,988	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	37,748,988	0	37,748,988	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,128,154	150,007	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,128,154	150,007	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	152,917	18,835	0	1,449,913	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	152,917	18,835	0	1,449,913	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 2/25/2020 4:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-115,553	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,017	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-170	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-852,068			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	4,849,475			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-145,585	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,788	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8 | Date/Time Prepared: 2/25/2020 4:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-19,252	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.02	PHYSICIAN RECRUITING	A	-25,605	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	ADVERTISING	A	-97,936	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HAF FEE	A	-1,045,352	ADMINISTRATIVE & GENERAL	5.00	0	33.04
34.00	LOBBYING	A	-854	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	340B	A	-11,195	DRUGS CHARGED TO PATIENTS	73.00	0	34.01
35.00	CRNA	A	-307,096	OPERATING ROOM	50.00	0	35.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,219,004				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2020 4:21 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,237,590	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,365,123	0	2.00
3.00	7.00	OPERATION OF PLANT	HOME OFFICE	476,990	0	3.00
3.01	9.00	HOUSEKEEPING	HOME OFFICE	190,412	0	3.01
3.02	10.00	DIETARY	HOME OFFICE	104,677	0	3.02
4.00	13.00	NURSING ADMINISTRATION	HOME OFFICE	75,932	0	4.00
4.01	15.00	PHARMACY	HOME OFFICE	323,733	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	86,662	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	174,385	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	527,501	838,129	4.04
4.05	13.00	NURSING ADMINISTRATION	HOME OFFICE	101,812	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	117,927	95,140	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,782,744	933,269	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2020 4:21 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	1,237,590	0		1.00
2.00	2,365,123	0		2.00
3.00	476,990	0		3.00
3.01	190,412	0		3.01
3.02	104,677	0		3.02
4.00	75,932	0		4.00
4.01	323,733	0		4.01
4.02	86,662	0		4.02
4.03	174,385	0		4.03
4.04	-310,628	0		4.04
4.05	101,812	0		4.05
4.06	22,787	0		4.06
5.00	4,849,475			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2020 4:21 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	30.00	ADULTS & PEDIATRICS	393,018	393,018	0	0	0	1.00
2.00	50.00	OPERATING ROOM	354,797	354,797	0	0	0	2.00
3.00	60.00	LABORATORY	40,000	0	40,000	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	81,201	81,201	0	0	0	4.00
5.00	76.00	INFUSION THERAPY	23,052	23,052	0	0	0	5.00
6.00	91.00	EMERGENCY	1,144,247	0	1,144,247	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			2,036,315	852,068	1,184,247		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	76.00	INFUSION THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	393,018		1.00
2.00	50.00	OPERATING ROOM	0	0	0	354,797		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	81,201		4.00
5.00	76.00	INFUSION THERAPY	0	0	0	23,052		5.00
6.00	91.00	EMERGENCY	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	852,068		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I Date/Time Prepared: 2/25/2020 4:21 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,449,913	1,449,913				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,843,611	11,693	0	1,855,304		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,068,569	69,766	0	204,135	7,342,470	5.00
7.00	00700	OPERATION OF PLANT	1,803,535	308,069	0	32,581	2,144,185	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,450	25,446	0	6,183	120,079	8.00
9.00	00900	HOUSEKEEPING	588,149	14,362	0	36,958	639,469	9.00
10.00	01000	DIETARY	478,506	37,623	0	24,517	540,646	10.00
11.00	01100	CAFETERIA	315,550	27,710	0	33,279	376,539	11.00
13.00	01300	NURSING ADMINISTRATION	212,527	4,309	0	5,755	222,591	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	316,383	0	0	23,953	340,336	14.00
15.00	01500	PHARMACY	929,962	0	0	18,694	948,656	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	477,960	20,810	0	36,018	534,788	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,087,287	127,730	0	183,912	2,398,929	30.00
31.00	03100	INTENSIVE CARE UNIT	7,416	30,223	0	863	38,502	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	863,746	79,679	0	112,553	1,055,978	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,481,909	54,576	0	94,114	1,630,599	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	155,980	6,557	0	0	162,537	54.03
60.00	06000	LABORATORY	1,722,818	23,885	0	107,604	1,854,307	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	45,637	0	0	0	45,637	62.00
65.00	06500	RESPIRATORY THERAPY	782,761	25,165	0	56,795	864,721	65.00
66.00	06600	PHYSICAL THERAPY	961,472	43,883	0	89,904	1,095,259	66.00
67.00	06700	OCCUPATIONAL THERAPY	296,738	12,770	0	33,892	343,400	67.00
68.00	06800	SPEECH PATHOLOGY	103,327	968	0	12,357	116,652	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	148,295	56,028	0	0	204,323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	553,194	0	0	0	553,194	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,057,213	15,798	0	0	1,073,011	73.00
76.00	03480	INFUSION THERAPY	125,843	16,657	0	11,006	153,506	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	292,699	0	0	25,899	318,598	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	1,960	0	0	0	1,960	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	384,685	24,587	0	27,796	437,068	90.03
91.00	09100	EMERGENCY	2,413,642	138,143	0	108,839	2,660,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	639,561	7,884	0	55,987	703,432	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,699,298	1,184,321	0	1,343,594	28,921,996	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	4,226,903	133,506	0	384,921	4,745,330	194.00
194.01	07951	FOUNDATION	56,998	20,435	0	7,120	84,553	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	1,350,906	111,651	0	119,669	1,582,226	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,334,105	1,449,913	0	1,855,304	35,334,105	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/25/2020 4:21 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,342,470					5.00
7.00	00700	OPERATION OF PLANT	562,439	2,706,624				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,498	64,951	216,528			8.00
9.00	00900	HOUSEKEEPING	167,738	36,659	0	843,866		9.00
10.00	01000	DIETARY	141,816	96,032	0	31,108	809,602	10.00
11.00	01100	CAFETERIA	98,770	70,729	0	22,912	0	11.00
13.00	01300	NURSING ADMINISTRATION	58,388	10,998	0	3,563	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	89,273	0	0	0	0	14.00
15.00	01500	PHARMACY	248,841	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	140,280	53,116	0	17,206	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	629,261	326,030	53,997	105,614	201,895	30.00
31.00	03100	INTENSIVE CARE UNIT	10,099	77,144	2,069	24,990	7,735	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	276,993	203,380	0	65,883	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	427,721	139,306	0	45,127	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	42,635	16,736	0	5,421	0	54.03
60.00	06000	LABORATORY	486,401	60,966	0	19,749	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,971	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	226,824	64,234	0	20,808	0	65.00
66.00	06600	PHYSICAL THERAPY	287,296	112,011	0	36,285	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	90,077	32,595	0	10,559	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,599	2,471	0	800	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,596	143,012	0	46,327	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,108	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	281,460	40,325	0	13,063	0	73.00
76.00	03480	INFUSION THERAPY	40,266	42,517	0	13,773	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	83,571	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	514	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	114,647	62,759	0	20,330	0	90.03
91.00	09100	EMERGENCY	697,906	352,609	0	114,223	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	184,517	20,123	0	6,519	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,660,505	2,028,703	56,066	624,260	209,630	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	1,244,754	340,774	0	110,390	0	194.00
194.01	07951	FOUNDATION	22,179	52,160	0	16,897	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	415,032	284,987	160,462	92,319	599,972	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,342,470	2,706,624	216,528	843,866	809,602	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/25/2020 4:21 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & 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	568,950					11.00
13.00	01300	NURSING ADMINISTRATION	2,659	298,199				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	429,609			14.00
15.00	01500	PHARMACY	0	0	1,445	1,198,942		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,641	0	13	0	762,044	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,967	117,925	11,422	0	40,771	30.00
31.00	03100	INTENSIVE CARE UNIT	399	771	0	0	1,274	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,002	24,344	48,449	0	52,982	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,483	0	8,257	0	131,271	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	9,740	0	4,731	54.03
60.00	06000	LABORATORY	49,715	0	115,024	0	86,504	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	10,284	0	977	62.00
65.00	06500	RESPIRATORY THERAPY	26,240	6,956	2,236	0	37,185	65.00
66.00	06600	PHYSICAL THERAPY	41,538	0	7,989	0	66,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,659	0	132	0	23,807	67.00
68.00	06800	SPEECH PATHOLOGY	5,709	0	0	0	8,012	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	34,628	0	5,296	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	129,393	0	10,866	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,637	6,032	4,764	1,198,942	65,850	73.00
76.00	03480	INFUSION THERAPY	5,085	9,800	0	0	3,288	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	399	0	3,368	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	89	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	8,039	14,820	2,642	0	27,480	90.03
91.00	09100	EMERGENCY	50,286	87,478	16,502	0	87,038	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	25,867	30,073	2,528	0	9,608	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	436,926	298,199	405,847	1,198,942	667,295	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	73,445	0	17,435	0	82,367	194.00
194.01	07951	FOUNDATION	3,289	0	0	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	55,290	0	6,327	0	12,382	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	568,950	298,199	429,609	1,198,942	762,044	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part I | Date/Time Prepared: 2/25/2020 4:21 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 SERVICE & 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	3,970,811	0	3,970,811		30.00
31.00	03100	INTENSIVE CARE UNIT	162,983	0	162,983		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,780,011	0	1,780,011		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,425,764	0	2,425,764		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	241,800	0	241,800		54.03
60.00	06000	LABORATORY	2,672,666	0	2,672,666		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	68,869	0	68,869		62.00
65.00	06500	RESPIRATORY THERAPY	1,249,204	0	1,249,204		65.00
66.00	06600	PHYSICAL THERAPY	1,647,276	0	1,647,276		66.00
67.00	06700	OCCUPATIONAL THERAPY	516,229	0	516,229		67.00
68.00	06800	SPEECH PATHOLOGY	164,243	0	164,243		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	487,182	0	487,182		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	838,561	0	838,561		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,692,084	0	2,692,084		73.00
76.00	03480	INFUSION THERAPY	268,235	0	268,235		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	405,936	0	405,936		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DIABETES	2,563	0	2,563		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
90.03	09003	PAIN MANAGEMENT	687,785	0	687,785		90.03
91.00	09100	EMERGENCY	4,066,666	0	4,066,666		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	982,667	0	982,667		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,331,535	0	25,331,535		118.00
		NONREIMBURSABLE COST CENTERS					
194.00	07950	MOB	6,614,495	0	6,614,495		194.00
194.01	07951	FOUNDATION	179,078	0	179,078		194.01
194.02	07952	ASC	0	0	0		194.02
194.03	07953	SNF - PERRY CO.	3,208,997	0	3,208,997		194.03
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)	35,334,105	0	35,334,105		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II Date/Time Prepared: 2/25/2020 4:21 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	11,693	0	11,693	11,693	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	69,766	0	69,766	1,287	5.00
7.00	00700	OPERATION OF PLANT	0	308,069	0	308,069	205	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,446	0	25,446	39	8.00
9.00	00900	HOUSEKEEPING	0	14,362	0	14,362	233	9.00
10.00	01000	DIETARY	0	37,623	0	37,623	155	10.00
11.00	01100	CAFETERIA	0	27,710	0	27,710	210	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,309	0	4,309	36	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	151	14.00
15.00	01500	PHARMACY	0	0	0	0	118	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,810	0	20,810	227	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	127,730	0	127,730	1,159	30.00
31.00	03100	INTENSIVE CARE UNIT	0	30,223	0	30,223	5	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	79,679	0	79,679	710	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,576	0	54,576	593	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	6,557	0	6,557	0	54.03
60.00	06000	LABORATORY	0	23,885	0	23,885	678	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	25,165	0	25,165	358	65.00
66.00	06600	PHYSICAL THERAPY	0	43,883	0	43,883	567	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,770	0	12,770	214	67.00
68.00	06800	SPEECH PATHOLOGY	0	968	0	968	78	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	56,028	0	56,028	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	15,798	0	15,798	0	73.00
76.00	03480	INFUSION THERAPY	0	16,657	0	16,657	69	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	163	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	24,587	0	24,587	175	90.03
91.00	09100	EMERGENCY	0	138,143	0	138,143	686	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	7,884	0	7,884	353	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,184,321	0	1,184,321	8,469	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	133,506	0	133,506	2,425	194.00
194.01	07951	FOUNDATION	0	20,435	0	20,435	45	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	111,651	0	111,651	754	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,449,913	0	1,449,913	11,693	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 2/25/2020 4:21 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	71,053					5.00
7.00	00700	OPERATION OF PLANT	5,442	313,716				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	305	7,528	33,318			8.00
9.00	00900	HOUSEKEEPING	1,623	4,249	0	20,467		9.00
10.00	01000	DIETARY	1,372	11,131	0	755	51,036	10.00
11.00	01100	CAFETERIA	956	8,198	0	556	0	11.00
13.00	01300	NURSING ADMINISTRATION	565	1,275	0	86	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	864	0	0	0	0	14.00
15.00	01500	PHARMACY	2,408	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,357	6,157	0	417	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,088	37,789	8,309	2,562	12,727	30.00
31.00	03100	INTENSIVE CARE UNIT	98	8,942	318	606	488	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,680	23,573	0	1,598	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,138	16,147	0	1,094	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	413	1,940	0	131	0	54.03
60.00	06000	LABORATORY	4,706	7,066	0	479	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	116	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,195	7,445	0	505	0	65.00
66.00	06600	PHYSICAL THERAPY	2,780	12,983	0	880	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	872	3,778	0	256	0	67.00
68.00	06800	SPEECH PATHOLOGY	296	286	0	19	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	519	16,576	0	1,124	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,404	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,723	4,674	0	317	0	73.00
76.00	03480	INFUSION THERAPY	390	4,928	0	334	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	809	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	5	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	1,109	7,274	0	493	0	90.03
91.00	09100	EMERGENCY	6,753	40,869	0	2,771	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,785	2,332	0	158	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,771	235,140	8,627	15,141	13,215	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	12,051	39,498	0	2,677	0	194.00
194.01	07951	FOUNDATION	215	6,046	0	410	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	4,016	33,032	24,691	2,239	37,821	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	71,053	313,716	33,318	20,467	51,036	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 2/25/2020 4:21 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & 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	37,630					11.00
13.00	01300	NURSING ADMINISTRATION	176	6,447				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	1,015			14.00
15.00	01500	PHARMACY	0	0	3	2,529		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,101	0	0	0	30,069	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,617	2,551	27	0	1,608	30.00
31.00	03100	INTENSIVE CARE UNIT	26	17	0	0	50	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,440	526	115	0	2,089	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,876	0	20	0	5,194	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	23	0	187	54.03
60.00	06000	LABORATORY	3,288	0	272	0	3,411	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	24	0	39	62.00
65.00	06500	RESPIRATORY THERAPY	1,736	150	5	0	1,466	65.00
66.00	06600	PHYSICAL THERAPY	2,747	0	19	0	2,638	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,036	0	0	0	939	67.00
68.00	06800	SPEECH PATHOLOGY	378	0	0	0	316	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	82	0	209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	306	0	428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	571	130	11	2,529	2,597	73.00
76.00	03480	INFUSION THERAPY	336	212	0	0	130	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1	0	133	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	4	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	532	320	6	0	1,084	90.03
91.00	09100	EMERGENCY	3,326	1,891	39	0	3,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,711	650	6	0	379	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,897	6,447	959	2,529	26,333	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	4,858	0	41	0	3,248	194.00
194.01	07951	FOUNDATION	218	0	0	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	3,657	0	15	0	488	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,630	6,447	1,015	2,529	30,069	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B Part II | Date/Time Prepared: 2/25/2020 4:21 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 SERVICE & 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	206,167	0	206,167		30.00
31.00	03100	INTENSIVE CARE UNIT	40,773	0	40,773		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	114,410	0	114,410		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,638	0	84,638		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	9,251	0	9,251		54.03
60.00	06000	LABORATORY	43,785	0	43,785		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	179	0	179		62.00
65.00	06500	RESPIRATORY THERAPY	39,025	0	39,025		65.00
66.00	06600	PHYSICAL THERAPY	66,497	0	66,497		66.00
67.00	06700	OCCUPATIONAL THERAPY	19,865	0	19,865		67.00
68.00	06800	SPEECH PATHOLOGY	2,341	0	2,341		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	74,538	0	74,538		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,138	0	2,138		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,350	0	29,350		73.00
76.00	03480	INFUSION THERAPY	23,056	0	23,056		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,106	0	1,106		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DIABETES	9	0	9		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
90.03	09003	PAIN MANAGEMENT	35,580	0	35,580		90.03
91.00	09100	EMERGENCY	197,910	0	197,910		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	15,258	0	15,258		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,005,876	0	1,005,876		118.00
		NONREIMBURSABLE COST CENTERS					
194.00	07950	MOB	198,304	0	198,304		194.00
194.01	07951	FOUNDATION	27,369	0	27,369		194.01
194.02	07952	ASC	0	0	0		194.02
194.03	07953	SNF - PERRY CO.	218,364	0	218,364		194.03
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)	1,449,913	0	1,449,913		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 4:21 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	92,877					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		92,877				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	749	749	13,711,707			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,469	4,469	1,508,671	-7,342,470	27,991,635	5.00
7.00	00700	OPERATION OF PLANT	19,734	19,734	240,792	0	2,144,185	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	1,630	45,699	0	120,079	8.00
9.00	00900	HOUSEKEEPING	920	920	273,143	0	639,469	9.00
10.00	01000	DIETARY	2,410	2,410	181,193	0	540,646	10.00
11.00	01100	CAFETERIA	1,775	1,775	245,948	0	376,539	11.00
13.00	01300	NURSING ADMINISTRATION	276	276	42,532	0	222,591	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	177,028	0	340,336	14.00
15.00	01500	PHARMACY	0	0	138,162	0	948,656	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	1,333	266,192	0	534,788	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	8,182	1,359,208	0	2,398,929	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	1,936	6,378	0	38,502	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	5,104	831,831	0	1,055,978	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	3,496	695,556	0	1,630,599	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	420	0	0	162,537	54.03
60.00	06000	LABORATORY	1,530	1,530	795,254	0	1,854,307	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	45,637	62.00
65.00	06500	RESPIRATORY THERAPY	1,612	1,612	419,746	0	864,721	65.00
66.00	06600	PHYSICAL THERAPY	2,811	2,811	664,442	0	1,095,259	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	818	250,479	0	343,400	67.00
68.00	06800	SPEECH PATHOLOGY	62	62	91,328	0	116,652	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,589	3,589	0	0	204,323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	553,194	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	1,012	0	0	1,073,011	73.00
76.00	03480	INFUSION THERAPY	1,067	1,067	81,343	0	153,506	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	191,410	0	318,598	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	1,960	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	1,575	1,575	205,431	0	437,068	90.03
91.00	09100	EMERGENCY	8,849	8,849	804,383	0	2,660,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	505	413,774	0	703,432	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,864	75,864	9,929,923	-7,342,470	21,579,526	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,552	8,552	2,844,745	0	4,745,330	194.00
194.01	07951	FOUNDATION	1,309	1,309	52,619	0	84,553	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	7,152	7,152	884,420	0	1,582,226	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,449,913	0	1,855,304		7,342,470	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.611109	0.000000	0.135308		0.262309	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,693		71,053	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000853		0.002538	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 4:21 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	67,925					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	9,211				8.00
9.00	00900	HOUSEKEEPING	920	0	65,375			9.00
10.00	01000	DIETARY	2,410	0	2,410	9,211		10.00
11.00	01100	CAFETERIA	1,775	0	1,775	0	9,101,074	11.00
13.00	01300	NURSING ADMINISTRATION	276	0	276	0	42,532	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	0	1,333	0	266,192	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	2,297	8,182	2,297	1,359,208	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	88	1,936	88	6,378	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	0	5,104	0	831,831	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	0	3,496	0	695,556	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	420	0	0	54.03
60.00	06000	LABORATORY	1,530	0	1,530	0	795,254	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,612	0	1,612	0	419,746	65.00
66.00	06600	PHYSICAL THERAPY	2,811	0	2,811	0	664,442	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	818	0	250,479	67.00
68.00	06800	SPEECH PATHOLOGY	62	0	62	0	91,328	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,589	0	3,589	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	0	1,012	0	138,162	73.00
76.00	03480	INFUSION THERAPY	1,067	0	1,067	0	81,343	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	1,575	0	1,575	0	128,595	90.03
91.00	09100	EMERGENCY	8,849	0	8,849	0	804,383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	0	505	0	413,774	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,912	2,385	48,362	2,385	6,989,203	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,552	0	8,552	0	1,174,832	194.00
194.01	07951	FOUNDATION	1,309	0	1,309	0	52,619	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	7,152	6,826	7,152	6,826	884,420	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,706,624	216,528	843,866	809,602	568,950	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.847243	23.507545	12.908084	87.895125	0.062515	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	313,716	33,318	20,467	51,036	37,630	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.618565	3.617197	0.313071	5.540766	0.004135	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet B-1 | Date/Time Prepared: 2/25/2020 4:21 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSE SALARIES)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)		
			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	2,465,907					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	1,836,716				14.00
15.00	01500	PHARMACY	0	6,178	1,068,408			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56	0	60,828,043		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	975,167	48,831	0	3,254,395		30.00
31.00	03100	INTENSIVE CARE UNIT	6,378	0	0	101,660		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	201,306	207,134	0	4,229,121		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,301	0	10,478,914		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	41,643	0	377,611		54.03
60.00	06000	LABORATORY	0	491,762	0	6,904,889		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	43,967	0	77,995		62.00
65.00	06500	RESPIRATORY THERAPY	57,523	9,561	0	2,968,161		65.00
66.00	06600	PHYSICAL THERAPY	0	34,156	0	5,339,892		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	565	0	1,900,320		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	639,531		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	148,047	0	422,754		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	553,194	0	867,308		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,877	20,366	1,068,408	5,256,253		73.00
76.00	03480	INFUSION THERAPY	81,038	0	0	262,429		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,706	0	268,843		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	DIABETES	0	0	0	7,128		90.01
90.02	09002	OP PSYCH	0	0	0	0		90.02
90.03	09003	PAIN MANAGEMENT	122,553	11,295	0	2,193,513		90.03
91.00	09100	EMERGENCY	723,383	70,552	0	6,947,475		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	248,682	10,810	0	766,887		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,465,907	1,735,124	1,068,408	53,265,079		118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	74,542	0	6,574,611		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	ASC	0	0	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	27,050	0	988,353		194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	298,199	429,609	1,198,942	762,044		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.120929	0.233901	1.122176	0.012528		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,447	1,015	2,529	30,069		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002614	0.000553	0.002367	0.000494		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 4:21 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	3,970,811		3,970,811	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	162,983		162,983	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,780,011		1,780,011	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,425,764		2,425,764	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	241,800		241,800	0	0	54.03
60.00	06000	LABORATORY	2,672,666		2,672,666	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	68,869		68,869	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,249,204	0	1,249,204	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,647,276	0	1,647,276	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	516,229	0	516,229	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	164,243	0	164,243	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	487,182		487,182	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	838,561		838,561	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,692,084		2,692,084	0	0	73.00
76.00	03480	INFUSION THERAPY	268,235		268,235	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	405,936		405,936	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	DIABETES	2,563		2,563	0	0	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	687,785		687,785	0	0	90.03
91.00	09100	EMERGENCY	4,066,666		4,066,666	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	837,408		837,408		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	982,667		982,667		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,168,943	0	26,168,943	0	0	200.00
201.00		Less Observation Beds	837,408		837,408		0	201.00
202.00		Total (see instructions)	25,331,535	0	25,331,535	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 4:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,480,793		2,480,793			30.00
31.00	03100	INTENSIVE CARE UNIT	101,660		101,660			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	150,064	4,079,057	4,229,121	0.420894	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	210,930	10,267,984	10,478,914	0.231490	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	7,853	369,758	377,611	0.640342	0.000000	54.03
60.00	06000	LABORATORY	789,721	6,115,168	6,904,889	0.387069	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	19,909	58,086	77,995	0.882992	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	580,099	2,388,062	2,968,161	0.420868	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	990,080	4,349,812	5,339,892	0.308485	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	463,767	1,436,553	1,900,320	0.271654	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	46,789	592,742	639,531	0.256818	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	307,242	115,512	422,754	1.152401	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,299	827,009	867,308	0.966855	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	938,388	4,317,865	5,256,253	0.512168	0.000000	73.00
76.00	03480	INFUSION THERAPY	200	262,229	262,429	1.022124	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	268,843	268,843			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DIABETES	0	7,128	7,128	0.359568	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	2,193,513	2,193,513	0.313554	0.000000	90.03
91.00	09100	EMERGENCY	207,399	6,740,076	6,947,475	0.585344	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	31,703	741,899	773,602	1.082479	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	766,887	766,887			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,366,896	45,898,183	53,265,079			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,366,896	45,898,183	53,265,079			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 4:21 pm

Title XVIII | Hospital | Cost

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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 4:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,970,811		3,970,811	0	3,970,811	30.00
31.00	03100	INTENSIVE CARE UNIT	162,983		162,983	0	162,983	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,780,011		1,780,011	0	1,780,011	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,425,764		2,425,764	0	2,425,764	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	241,800		241,800	0	241,800	54.03
60.00	06000	LABORATORY	2,672,666		2,672,666	0	2,672,666	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	68,869		68,869	0	68,869	62.00
65.00	06500	RESPIRATORY THERAPY	1,249,204	0	1,249,204	0	1,249,204	65.00
66.00	06600	PHYSICAL THERAPY	1,647,276	0	1,647,276	0	1,647,276	66.00
67.00	06700	OCCUPATIONAL THERAPY	516,229	0	516,229	0	516,229	67.00
68.00	06800	SPEECH PATHOLOGY	164,243	0	164,243	0	164,243	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	487,182		487,182	0	487,182	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	838,561		838,561	0	838,561	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,692,084		2,692,084	0	2,692,084	73.00
76.00	03480	INFUSION THERAPY	268,235		268,235	0	268,235	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	405,936		405,936	0	405,936	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	DIABETES	2,563		2,563	0	2,563	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	687,785		687,785	0	687,785	90.03
91.00	09100	EMERGENCY	4,066,666		4,066,666	0	4,066,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	837,408		837,408		837,408	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	982,667		982,667		982,667	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,168,943	0	26,168,943	0	26,168,943	200.00
201.00		Less Observation Beds	837,408		837,408		837,408	201.00
202.00		Total (see instructions)	25,331,535	0	25,331,535	0	25,331,535	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 4:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,480,793		2,480,793			30.00
31.00	03100	INTENSIVE CARE UNIT	101,660		101,660			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	150,064	4,079,057	4,229,121	0.420894	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	210,930	10,267,984	10,478,914	0.231490	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	7,853	369,758	377,611	0.640342	0.000000	54.03
60.00	06000	LABORATORY	789,721	6,115,168	6,904,889	0.387069	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	19,909	58,086	77,995	0.882992	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	580,099	2,388,062	2,968,161	0.420868	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	990,080	4,349,812	5,339,892	0.308485	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	463,767	1,436,553	1,900,320	0.271654	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	46,789	592,742	639,531	0.256818	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	307,242	115,512	422,754	1.152401	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,299	827,009	867,308	0.966855	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	938,388	4,317,865	5,256,253	0.512168	0.000000	73.00
76.00	03480	INFUSION THERAPY	200	262,229	262,429	1.022124	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	268,843	268,843	1.509937	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DIABETES	0	7,128	7,128	0.359568	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	2,193,513	2,193,513	0.313554	0.000000	90.03
91.00	09100	EMERGENCY	207,399	6,740,076	6,947,475	0.585344	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	31,703	741,899	773,602	1.082479	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	766,887	766,887			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,366,896	45,898,183	53,265,079			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,366,896	45,898,183	53,265,079			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet C Part I Date/Time Prepared: 2/25/2020 4:21 pm

Title XIX | Hospital | Cost

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part II Date/Time Prepared: 2/25/2020 4:21 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	114,410	4,229,121	0.027053	42,167	1,141	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,638	10,478,914	0.008077	87,412	706	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	9,251	377,611	0.024499	5,012	123	54.03
60.00	06000	LABORATORY	43,785	6,904,889	0.006341	220,964	1,401	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	179	77,995	0.002295	8,334	19	62.00
65.00	06500	RESPIRATORY THERAPY	39,025	2,968,161	0.013148	163,437	2,149	65.00
66.00	06600	PHYSICAL THERAPY	66,497	5,339,892	0.012453	50,173	625	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,865	1,900,320	0.010454	22,384	234	67.00
68.00	06800	SPEECH PATHOLOGY	2,341	639,531	0.003660	7,824	29	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	74,538	422,754	0.176315	92,098	16,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,138	867,308	0.002465	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,350	5,256,253	0.005584	191,717	1,071	73.00
76.00	03480	INFUSION THERAPY	23,056	262,429	0.087856	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,106	268,843	0.004114	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	DIABETES	9	7,128	0.001263	0	0	90.01
90.02	09002	OP PSYCH	0	0	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	35,580	2,193,513	0.016221	0	0	90.03
91.00	09100	EMERGENCY	197,910	6,947,475	0.028487	2,824	80	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	43,479	773,602	0.056203	1,580	89	92.00
200.00		Total (lines 50 through 199)	787,157	49,915,739		895,926	23,905	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 2/25/2020 4:21 pm

Title XVIII | Hospital | Cost

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV Date/Time Prepared: 2/25/2020 4:21 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	4,229,121	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,478,914	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	377,611	0.000000	54.03
60.00	06000	LABORATORY	0	0	0	6,904,889	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	77,995	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,968,161	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,339,892	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,900,320	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	639,531	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	422,754	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	867,308	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,256,253	0.000000	73.00
76.00	03480	INFUSION THERAPY	0	0	0	262,429	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	268,843	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	DIABETES	0	0	0	7,128	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	2,193,513	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	6,947,475	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	773,602	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	49,915,739		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part IV | Date/Time Prepared: 2/25/2020 4:21 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	42,167	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	87,412	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	5,012	0	0	0	54.03
60.00	06000	LABORATORY	0.000000	220,964	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	8,334	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	163,437	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	50,173	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	22,384	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,824	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	92,098	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	191,717	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	0.000000	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	2,824	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,580	0	0	0	92.00
200.00		Total (lines 50 through 199)		895,926	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/25/2020 4:21 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	0.420894	0	1,663,141	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231490	0	2,428,536	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.640342	0	146,546	0	0	54.03
60.00	06000	LABORATORY	0.387069	0	1,846,127	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.882992	0	12,964	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.420868	0	792,559	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.308485	0	1,597,568	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.271654	0	355,180	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.256818	0	37,874	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.152401	0	110,311	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.966855	0	418,651	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.512168	0	1,709,900	6,782	0	73.00
76.00	03480	INFUSION THERAPY	1.022124	0	97,955	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	0.359568	0	2,160	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.313554	0	686,021	0	0	90.03
91.00	09100	EMERGENCY	0.585344	0	1,665,285	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.082479	0	291,867	95	0	92.00
200.00		Subtotal (see instructions)		0	13,862,645	6,877	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	13,862,645	6,877	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/25/2020 4:21 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	700,006	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	562,182	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	93,840	0		54.03
60.00	06000	LABORATORY	714,579	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,447	0		62.00
65.00	06500	RESPIRATORY THERAPY	333,563	0		65.00
66.00	06600	PHYSICAL THERAPY	492,826	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	96,486	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,727	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127,123	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	404,775	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	875,756	3,474		73.00
76.00	03480	INFUSION THERAPY	100,122	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	777	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	215,105	0		90.03
91.00	09100	EMERGENCY	974,765	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	315,940	103		92.00
200.00		Subtotal (see instructions)	6,029,019	3,577		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,029,019	3,577		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/25/2020 4:21 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	0.420894	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231490	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.640342	0	0	0	0	54.03
60.00	06000	LABORATORY	0.387069	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.882992	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.420868	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.308485	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.271654	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.256818	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.152401	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.966855	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.512168	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	1.022124	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	0.359568	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.313554	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.585344	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.082479	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D Part V Date/Time Prepared: 2/25/2020 4:21 pm

Title XVIII | Swing Beds - SNF | Cost

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 4:21 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)	3,663	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,513	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)	880	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)	1,417	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)	733	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	513	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)	1,417	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)	3,970,811	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)	94,660	25.00
26.00	Total swing-bed cost (see instructions)	1,969,238	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,001,573	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,001,573	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)	1,322.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	678,658	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)	678,658	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 4:21 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	162,983	88	1,852.08	23	42,598	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)	434,120	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,155,376	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)	1,874,578	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,874,578	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)	633	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,322.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	837,408	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 4:21 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	206,167	3,970,811	0.051921	837,408	43,479	90.00
91.00	Nursing School cost	0	3,970,811	0.000000	837,408	0	91.00
92.00	Allied health cost	0	3,970,811	0.000000	837,408	0	92.00
93.00	All other Medical Education	0	3,970,811	0.000000	837,408	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 4:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,663	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,513	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)	880	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)	1,417	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)	733	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	15	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,970,811	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,920,361	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,050,450	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,050,450	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)	1,355.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	20,328	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)	20,328	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 4:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	162,983	88	1,852.08	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	20,055	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	40,383	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	633	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,355.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	857,854	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-1 | Date/Time Prepared: 2/25/2020 4:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	206,167	3,970,811	0.051921	857,854	44,541	90.00
91.00	Nursing School cost	0	3,970,811	0.000000	857,854	0	91.00
92.00	Allied health cost	0	3,970,811	0.000000	857,854	0	92.00
93.00	All other Medical Education	0	3,970,811	0.000000	857,854	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 2/25/2020 4:21 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		461,880		30.00
31.00	03100	INTENSIVE CARE UNIT		44,965		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.420894	42,167	17,748	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231490	87,412	20,235	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.640342	5,012	3,209	54.03
60.00	06000	LABORATORY	0.387069	220,964	85,528	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.882992	8,334	7,359	62.00
65.00	06500	RESPIRATORY THERAPY	0.420868	163,437	68,785	65.00
66.00	06600	PHYSICAL THERAPY	0.308485	50,173	15,478	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.271654	22,384	6,081	67.00
68.00	06800	SPEECH PATHOLOGY	0.256818	7,824	2,009	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.152401	92,098	106,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.966855	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.512168	191,717	98,191	73.00
76.00	03480	INFUSION THERAPY	1.022124	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	0.359568	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.313554	0	0	90.03
91.00	09100	EMERGENCY	0.585344	2,824	1,653	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.082479	1,580	1,710	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		895,926	434,120	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)		895,926		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3

Component CCN: 15-Z319 | Date/Time Prepared: 2/25/2020 4:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.420894	8,606	3,622	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231490	35,248	8,160	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.640342	1,045	669	54.03
60.00	06000	LABORATORY	0.387069	203,823	78,894	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.882992	3,704	3,271	62.00
65.00	06500	RESPIRATORY THERAPY	0.420868	149,981	63,122	65.00
66.00	06600	PHYSICAL THERAPY	0.308485	460,918	142,186	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.271654	217,382	59,053	67.00
68.00	06800	SPEECH PATHOLOGY	0.256818	22,848	5,868	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.152401	113,038	130,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.966855	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.512168	272,515	139,573	73.00
76.00	03480	INFUSION THERAPY	1.022124	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	0.359568	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.313554	0	0	90.03
91.00	09100	EMERGENCY	0.585344	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.082479	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,489,108	634,683	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,489,108		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet D-3 | Date/Time Prepared: 2/25/2020 4:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		15,068		30.00
31.00	03100	INTENSIVE CARE UNIT		1,908		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.420894	6,583	2,771	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231490	8,134	1,883	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.640342	622	398	54.03
60.00	06000	LABORATORY	0.387069	18,197	7,043	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.882992	347	306	62.00
65.00	06500	RESPIRATORY THERAPY	0.420868	8,101	3,409	65.00
66.00	06600	PHYSICAL THERAPY	0.308485	538	166	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.271654	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.256818	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.152401	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.966855	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.512168	0	0	73.00
76.00	03480	INFUSION THERAPY	1.022124	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.509937	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	0.359568	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.313554	0	0	90.03
91.00	09100	EMERGENCY	0.585344	6,968	4,079	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.082479	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		49,490	20,055	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)		49,490		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E Part B Date/Time Prepared: 2/25/2020 4:21 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,032,596	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,032,596	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,092,922	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)	45,808	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,358,877	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,688,237	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,688,237	30.00
31.00	Primary payer payments	5,518	31.00
32.00	Subtotal (line 30 minus line 31)	3,682,719	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)	339,957	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	220,972	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	320,230	36.00
37.00	Subtotal (see instructions)	3,903,691	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,903,691	40.00
40.01	Sequestration adjustment (see instructions)	78,074	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,879,732	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-54,115	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-1 Part I Date/Time Prepared: 2/25/2020 4:21 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,105,891		3,812,432	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	05/01/2019	67,300	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		67,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,105,891		3,879,732	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		129,652		54,115	6.02
7.00	Total Medicare program liability (see instructions)		976,239		3,825,617	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2020 4:21 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		2,767,314		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)		2,767,314		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		298,659		0	6.02
7.00	Total Medicare program liability (see instructions)		2,468,655		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1319	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/25/2020 4:21 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1319 Component CCN: 15-Z319	Period: From 10/01/2018 To 09/30/2019	Worksheet E-2 Date/Time Prepared: 2/25/2020 4:21 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,893,324	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)	641,030	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	1,417	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)	2,534,354	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,534,354	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)	2,534,354	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	15,318	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)	2,519,036	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)	2,519,036	0	19.00
19.01	Sequestration adjustment (see instructions)	50,381	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	2,767,314	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)	-298,659	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1319	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Prepared: 2/25/2020 4:21 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,155,376	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,155,376	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,166,930	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,166,930	19.00
20.00	Deductibles (exclude professional component)	180,058	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	986,872	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	986,872	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14,293	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,290	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,061	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	996,162	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)	996,162	30.00
30.01	Sequestration adjustment (see instructions)	19,923	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,105,891	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)	-129,652	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet E-3 Part VII | Date/Time Prepared: 2/25/2020 4:21 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	40,383		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)	40,383	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)	40,383	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	16,976		8.00
9.00	Ancillary service charges	49,490	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)	66,466	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)	66,466	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	26,083	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)	40,383	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)	40,383	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)	40,383	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)	40,383	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	40,383	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)	40,383	0	40.00
41.00	Interim payments	19,808	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	20,575	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G | Date/Time Prepared: 2/25/2020 4:21 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	5,582,823	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,337,816	0	0	0	4.00
5.00	Other receivable	396,345	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,068,913	0	0	0	6.00
7.00	Inventory	689,106	0	0	0	7.00
8.00	Prepaid expenses	703,024	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)	10,640,201	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	421,244	0	0	0	12.00
13.00	Land improvements	258,790	0	0	0	13.00
14.00	Accumulated depreciation	-186,255	0	0	0	14.00
15.00	Buildings	19,828,965	0	0	0	15.00
16.00	Accumulated depreciation	-12,664,921	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	5,676,469	0	0	0	19.00
20.00	Accumulated depreciation	-3,412,250	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	10,612,304	0	0	0	23.00
24.00	Accumulated depreciation	-8,312,826	0	0	0	24.00
25.00	Minor equipment depreciable	951,216	0	0	0	25.00
26.00	Accumulated depreciation	-629,543	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)	12,543,193	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,618,629	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,618,629	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,802,023	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,252,578	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,650,336	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	176,874	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	2,338,963	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,418,751	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,100,267	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,100,267	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,519,018	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,283,005				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	10,283,005	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,802,023	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-1 | Date/Time Prepared: 2/25/2020 4:21 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		10,248,421		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		34,584				2.00
3.00	Total (sum of line 1 and line 2)		10,283,005		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,283,005		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,283,005		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2020 4:21 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,480,793		2,480,793	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,480,793		2,480,793	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	101,660		101,660	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)	101,660		101,660	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,582,453		2,582,453	17.00
18.00	Ancillary services	4,545,341	35,179,837	39,725,178	18.00
19.00	Outpatient services	239,102	9,682,616	9,921,718	19.00
20.00	RURAL HEALTH CLINIC	0	268,843	268,843	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		766,887	766,887	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MOB	-1,406	6,286,542	6,285,136	27.00
27.01	SNF PERRY CO	988,353	0	988,353	27.01
27.02	PRO FEES	0	927,093	927,093	27.02
27.03	PROFESSIONAL	1,465	545,906	547,371	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,355,308	53,657,724	62,013,032	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,115,101		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)		33,115,101		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2018 To 09/30/2019 | Worksheet G-3 | Date/Time Prepared: 2/25/2020 4:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,013,032	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,589,666	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,423,366	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,115,101	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-691,735	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	392,083	6.00
7.00	Income from investments	115,553	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	145,585	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	69,933	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	3,165	24.00
25.00	Total other income (sum of lines 6-24)	726,319	25.00
26.00	Total (line 5 plus line 25)	34,584	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)	34,584	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H | Date/Time Prepared: 2/25/2020 4:21 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	98,086	23,753	37,125	0	69,391	228,355	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	229,358	55,543	0	0	0	284,901	6.00
7.00	Physical Therapy	45,148	10,933	0	0	0	56,081	7.00
8.00	Occupational Therapy	8,862	2,146	0	0	0	11,008	8.00
9.00	Speech Pathology	2,223	538	0	0	0	2,761	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	30,097	7,289	0	0	0	37,386	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	189	189	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)	413,774	100,202	37,125	0	69,580	620,681	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	19,069	247,424	0	247,424			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	284,901	0	284,901			6.00
7.00	Physical Therapy	0	56,081	0	56,081			7.00
8.00	Occupational Therapy	0	11,008	0	11,008			8.00
9.00	Speech Pathology	0	2,761	0	2,761			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	37,386	0	37,386			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	-189	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)	18,880	639,561	0	639,561			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-1 Part I | Date/Time Prepared: 2/25/2020 4:21 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	247,424	0	0	0	0	247,424	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	284,901	0	0	0	0	284,901	6.00
7.00	Physical Therapy	56,081	0	0	0	0	56,081	7.00
8.00	Occupational Therapy	11,008	0	0	0	0	11,008	8.00
9.00	Speech Pathology	2,761	0	0	0	0	2,761	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	37,386	0	0	0	0	37,386	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)	639,561	0	0	0	0	639,561	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	247,424		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	179,762	464,663	6.00
7.00	Physical Therapy	35,385	91,466	7.00
8.00	Occupational Therapy	6,946	17,954	8.00
9.00	Speech Pathology	1,742	4,503	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	23,589	60,975	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)		639,561	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-1 Part II | Date/Time Prepared: 2/25/2020 4:21 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	-247,424	392,137	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	284,901	6.00
7.00	Physical Therapy	0	0	0	0	0	56,081	7.00
8.00	Occupational Therapy	0	0	0	0	0	11,008	8.00
9.00	Speech Pathology	0	0	0	0	0	2,761	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	37,386	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	-247,424	392,137	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		247,424	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.630963	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-2 Part I | Date/Time Prepared: 2/25/2020 4:21 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	7,884	0	55,987	63,871	16,754	1.00
2.00	Skilled Nursing Care	464,663	0	0	0	464,663	121,886	2.00
3.00	Physical Therapy	91,466	0	0	0	91,466	23,992	3.00
4.00	Occupational Therapy	17,954	0	0	0	17,954	4,710	4.00
5.00	Speech Pathology	4,503	0	0	0	4,503	1,181	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	60,975	0	0	0	60,975	15,994	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)	639,561	7,884	0	55,987	703,432	184,517	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	20,123	0	6,519	0	25,867	30,073	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	20,123	0	6,519	0	25,867	30,073	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-2 Part I Date/Time Prepared: 2/25/2020 4:21 pm

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICE & 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	2,528	0	9,608	175,343	0	175,343	1.00
2.00	Skilled Nursing Care	0	0	0	586,549	0	586,549	2.00
3.00	Physical Therapy	0	0	0	115,458	0	115,458	3.00
4.00	Occupational Therapy	0	0	0	22,664	0	22,664	4.00
5.00	Speech Pathology	0	0	0	5,684	0	5,684	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	76,969	0	76,969	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)	2,528	0	9,608	982,667	0	982,667	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	127,393	713,942	2.00
3.00	Physical Therapy	25,076	140,534	3.00
4.00	Occupational Therapy	4,922	27,586	4.00
5.00	Speech Pathology	1,235	6,919	5.00
6.00	Medical Social Services	0	0	6.00
7.00	Home Health Aide	16,717	93,686	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)	175,343	982,667	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.	0.217190		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-2 Part II | Date/Time Prepared: 2/25/2020 4:21 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	505	505	413,774	0	63,871	505	1.00
2.00	Skilled Nursing Care	0	0	0	0	464,663	0	2.00
3.00	Physical Therapy	0	0	0	0	91,466	0	3.00
4.00	Occupational Therapy	0	0	0	0	17,954	0	4.00
5.00	Speech Pathology	0	0	0	0	4,503	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	60,975	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	505	505	413,774		703,432	505	20.00
21.00	Total cost to be allocated	7,884	0	55,987		184,517	20,123	21.00
22.00	Unit cost multiplier	15.611881	0.000000	0.135308		0.262310	39.847525	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSE SALARIES)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	505	0	413,774	248,682	10,810	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	505	0	413,774	248,682	10,810	20.00
21.00	Total cost to be allocated	0	6,519	0	25,867	30,073	2,528	21.00
22.00	Unit cost multiplier	0.000000	12.908911	0.000000	0.062515	0.120930	0.233858	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

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

Worksheet H-2 Part II
Date/Time Prepared: 2/25/2020 4:21 pm

Home Health Agency I

PPS

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)				
		15.00	16.00				
1.00	Administrative and General	0	766,887				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	766,887				20.00
21.00	Total cost to be allocated	0	9,608				21.00
22.00	Unit cost multiplier	0.000000	0.012529				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-3 Part I Date/Time Prepared: 2/25/2020 4:21 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	713,942		713,942	2,674	266.99	1.00
2.00	Physical Therapy	3.00	140,534	0	140,534	1,564	89.86	2.00
3.00	Occupational Therapy	4.00	27,586	0	27,586	307	89.86	3.00
4.00	Speech Pathology	5.00	6,919	0	6,919	77	89.86	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	93,686		93,686	304	308.18	6.00
7.00	Total (sum of lines 1-6)		982,667	0	982,667	4,926		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	1,475			8.00
9.00	Physical Therapy		99915	0	946			9.00
10.00	Occupational Therapy		99915	0	180			10.00
11.00	Speech Pathology		99915	0	23			11.00
12.00	Medical Social Services		99915	0	0			12.00
13.00	Home Health Aide		99915	0	240			13.00
14.00	Total (sum of lines 8-13)			0	2,864			14.00

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

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,475		0	393,810		1.00
2.00	Physical Therapy	0	946		0	85,008		2.00
3.00	Occupational Therapy	0	180		0	16,175		3.00
4.00	Speech Pathology	0	23		0	2,067		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	240		0	73,963		6.00
7.00	Total (sum of lines 1-6)	0	2,864		0	571,023		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-3 Part I Date/Time Prepared: 2/25/2020 4:21 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	29,862	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	393,810	1.00
2.00	Physical Therapy	85,008	2.00
3.00	Occupational Therapy	16,175	3.00
4.00	Speech Pathology	2,067	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	73,963	6.00
7.00	Total (sum of lines 1-6)	571,023	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-3 Part II | Date/Time Prepared: 2/25/2020 4:21 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	0.308485	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.271654	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.256818	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	1.152401	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.512168	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/25/2020 4:21 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	384,497	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	8,690	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	7,639	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,358	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	3,282	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	405,466	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	405,466	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	405,466	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	405,466	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	405,466	31.00
31.01	Sequestration adjustment (see instructions)	0	8,109	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	397,356	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2018 To 09/30/2019 | Worksheet H-5 Date/Time Prepared: 2/25/2020 4:21 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		397,356	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		397,356	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		397,357	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2018 To 09/30/2019 | Worksheet M-1 | Date/Time Prepared: 2/25/2020 4:21 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	122,513	0	122,513	0	122,513	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	15,848	0	15,848	0	15,848	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	138,361	0	138,361	0	138,361	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	138,361	0	138,361	0	138,361	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	5,686	5,686	0	5,686	29.00
30.00	Administrative Costs	53,049	97,354	150,403	-1,751	148,652	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	53,049	103,040	156,089	-1,751	154,338	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	191,410	103,040	294,450	-1,751	292,699	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2018 To 09/30/2019 | Worksheet M-1 | Date/Time Prepared: 2/25/2020 4:21 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	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	122,513		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	15,848		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	138,361		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	138,361		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	5,686		29.00
30.00	Administrative Costs	0	148,652		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	154,338		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	292,699		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2018 To 09/30/2019 | Worksheet M-2 | Date/Time Prepared: 2/25/2020 4:21 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	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.86	537	2,100	1,806		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.86	537		1,806	1,806	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.86	537			1,806	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)					138,361	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					138,361	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					154,338	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					113,237	15.00
16.00	Total overhead (sum of lines 14 and 15)					267,575	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					267,575	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					267,575	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					405,936	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/25/2020 4:21 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)		405,936	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		20,855	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		385,081	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,806	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,806	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		213.22	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)	213.22	213.22	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	167	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	35,608	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	35,608	16.00
16.01	Total program charges (see instructions)(from contractor's records)		37,253	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,080	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,988	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.)		25,154	16.04
16.05	Total program cost (see instructions)	0	27,142	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,177	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,599	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		27,142	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,342	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		28,484	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)		28,484	26.00
26.01	Sequestration adjustment (see instructions)		570	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		22,073	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)		5,841	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/25/2020 4:21 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)	138,361	138,361	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000468	0.013109	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	65	1,814	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	741	4,488	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	806	6,302	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	138,361	138,361	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	267,575	267,575	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005825	0.045548	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,559	12,188	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,365	18,490	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	5	140	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	473.00	132.07	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	3	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	946	396	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)		20,855	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)		1,342	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/25/2020 4:21 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		22,073	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)		22,073	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		5,841	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		27,914	7.00

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