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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/22/2018 3:52 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/22/2018 Time: 3:52 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CAMERON MEMORIAL COMMUNITY (15-1315) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 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	-127,765	412,491	0	-106,046	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	25,794	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-101,971	412,491	0	-106,046	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 11:52 am

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CAMERON MEMORIAL COMMUNITY	151315	99915	1	02/01/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	CAMERON HOME HEALTH CARE	157117	99915		04/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	CAMERON HOSPICE	151561	99915		05/01/1997				14.00
15.00	Hospital-Based Health Clinic - RHC									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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	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	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 11:52 am

		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)	N		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) or (ii)? 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) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 11:52 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			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

	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	

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 11:52 am

			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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.		N	87.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 11:52 am

		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:	245,357	0	0	118.01

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/22/2018 11:52 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/19/2021	Y	12/19/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/22/2018 11:52 am

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/22/2018 11:52 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/22/2018 11:52 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,395	70,224.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		23	8,395	70,224.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	4,944.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	75,168.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/22/2018 11:52 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,103	75	2,926			1.00
2.00	HMO and other (see instructions)	33	261				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	315	0	315			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	199			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,418	75	3,440			7.00
8.00	INTENSIVE CARE UNIT	79	19	206			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	406			13.00
14.00	Total (see instructions)	1,497	94	4,052	0.00	363.60	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	1,027	1,176	5,407	0.00	8.30	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	2.29	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	374.19	27.00
28.00	Observation Bed Days		173	1,336			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	2	25			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/22/2018 11:52 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	434	34	1,256	1.00
2.00	HMO and other (see instructions)			15	97		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	434	34	1,256	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 15-1315 | Component CCN: 15-7117 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-4 | Date/Time Prepared: 2/22/2018 11:52 am

Home Health Agency I | PPS

		1.00	
0.00	County	STEUBEN	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	72.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel		3.13	0.00	3.13	5.00
6.00	Direct Nursing Service		3.69	0.00	3.69	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		1.92	0.00	1.92	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.33	0.00	0.33	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.03	0.00	0.03	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		1.57	0.00	1.57	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	Full Episodes 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	268	15	31	7	321	21.00
22.00	Skilled Nursing Visit Charges	46,462	2,916	5,832	1,361	56,571	22.00
23.00	Physical Therapy Visits	521	15	8	13	557	23.00
24.00	Physical Therapy Visit Charges	105,314	3,079	1,642	2,669	112,704	24.00
25.00	Occupational Therapy Visits	29	12	0	1	42	25.00
26.00	Occupational Therapy Visit Charges	5,759	2,383	0	198	8,340	26.00
27.00	Speech Pathology Visits	17	0	0	0	17	27.00
28.00	Speech Pathology Visit Charges	3,376	0	0	0	3,376	28.00
29.00	Medical Social Service Visits	8	0	0	0	8	29.00
30.00	Medical Social Service Visit Charges	1,973	0	0	0	1,973	30.00
31.00	Home Health Aide Visits	69	10	3	0	82	31.00
32.00	Home Health Aide Visit Charges	3,627	526	158	0	4,311	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	912	52	42	21	1,027	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)	166,511	8,904	7,632	4,228	187,275	35.00
36.00	Total Number of Episodes (standard/non outlier)	68		14	1	83	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	2,429	0	903	0	3,332	38.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-9 PARTS I THROUGH IV | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	1,320	150	615	2,085	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	0	0	13	13	13.00
14.00	Total Hospice Days	1,320	150	628	2,098	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/22/2018 11:52 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.408307	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,229,375	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,454,424	5.00
6.00	Medicaid charges	12,313,258	6.00
7.00	Medicaid cost (line 1 times line 6)	5,027,589	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)	1,343,790	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)	1,343,790	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)	169,094	25,542	194,636	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	69,042	25,542	94,584	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)	69,042	25,542	94,584	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)	7,324,774	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	469,844	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	722,837	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	6,601,937	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,948,610	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,043,194	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,386,984	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,040,550	6,040,550	-485,863	5,554,687	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,760,756	1,760,756	2,229,327	3,990,083	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,668,521	6,668,521	0	6,668,521	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,647,323	6,254,469	9,901,792	499,433	10,401,225	5.00
7.00	00700	OPERATION OF PLANT	765,147	1,729,829	2,494,976	32,915	2,527,891	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,385	33,385	0	33,385	8.00
9.00	00900	HOUSEKEEPING	629,272	388,051	1,017,323	0	1,017,323	9.00
10.00	01000	DIETARY	425,392	378,367	803,759	-628,326	175,433	10.00
11.00	01100	CAFETERIA	0	0	0	589,751	589,751	11.00
13.00	01300	NURSING ADMINISTRATION	630,555	47,421	677,976	0	677,976	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	170,592	90,665	261,257	0	261,257	14.00
15.00	01500	PHARMACY	438,790	2,411,560	2,850,350	0	2,850,350	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	429,972	236,992	666,964	0	666,964	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,079,957	1,387,240	3,467,197	352,957	3,820,154	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	195,897	195,897	31.00
43.00	04300	NURSERY	0	0	0	54,870	54,870	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,775,382	1,289,688	3,065,070	-687,058	2,378,012	50.00
51.00	05100	RECOVERY ROOM	0	0	0	687,058	687,058	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	807,576	169,557	977,133	-605,351	371,782	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,588,994	894,461	2,483,455	0	2,483,455	54.00
60.00	06000	LABORATORY	902,585	1,753,047	2,655,632	0	2,655,632	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	39,433	872,234	911,667	-160,309	751,358	65.00
65.01	06501	SLEEP LAB	0	0	0	186,746	186,746	65.01
66.00	06600	PHYSICAL THERAPY	847,890	32,656	880,546	0	880,546	66.00
69.00	06900	ELECTROCARDIOLOGY	0	367,084	367,084	-26,437	340,647	69.00
69.01	06901	CARDIAC REHAB	67,574	4,071	71,645	0	71,645	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2	1,093,243	1,093,245	-651,273	441,972	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	651,273	651,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	101,970	69,666	171,636	0	171,636	76.00
76.01	03480	ONCOLOGY	0	1,096,544	1,096,544	0	1,096,544	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	145,896	25,252	171,148	0	171,148	90.00
90.01	09001	CLINIC- MCDONALD	484,294	956,475	1,440,769	-35,416	1,405,353	90.01
91.00	09100	EMERGENCY	1,736,514	405,140	2,141,654	1,627	2,143,281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	711,392	70,750	782,142	-143,502	638,640	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,697,836	1,697,836	-1,697,836	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	86,579	29,734	116,313	30,062	146,375	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,513,081	38,255,244	56,768,325	390,545	57,158,870	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	21,039	21,039	14,377	35,416	194.01
194.02	07952	COMMUNITY HEALTH	77,410	7,185	84,595	0	84,595	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	94,461	99,784	194,245	-166,745	27,500	194.04
194.05	07955	MARKETING	136,032	395,731	531,763	-104,094	427,669	194.05
194.06	07956	GUEST MEALS	0	0	0	38,575	38,575	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	1,302,332	280,828	1,583,160	-160,782	1,422,378	194.09
194.10	07960	RHC	602,353	105,325	707,678	-11,876	695,802	194.10
194.11	07961	OBGYN	70,328	10,685	81,013	0	81,013	194.11
194.12	07962	TRINE STUDENT HEALTH	14,879	814	15,693	0	15,693	194.12
194.13	07963	OCCUPATIONAL HEALTH	112,718	40,111	152,829	0	152,829	194.13
194.14	07964	IMMUNIZATION CLINIC	57,430	1,160	58,590	0	58,590	194.14
200.00		TOTAL (SUM OF LINES 118 through 199)	20,981,024	39,217,906	60,198,930	0	60,198,930	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-633,910	4,920,777	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-167,257	3,822,826	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-394,171	6,274,350	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,877,961	8,523,264	5.00
7.00	00700	OPERATION OF PLANT	-3,300	2,524,591	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,385	8.00
9.00	00900	HOUSEKEEPING	0	1,017,323	9.00
10.00	01000	DIETARY	-13,741	161,692	10.00
11.00	01100	CAFETERIA	-305,753	283,998	11.00
13.00	01300	NURSING ADMINISTRATION	0	677,976	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	261,257	14.00
15.00	01500	PHARMACY	-86,222	2,764,128	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-401	666,563	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-1,074,034	2,746,120	30.00
31.00	03100	INTENSIVE CARE UNIT	0	195,897	31.00
43.00	04300	NURSERY	0	54,870	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-633,019	1,744,993	50.00
51.00	05100	RECOVERY ROOM	0	687,058	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	371,782	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,483,455	54.00
60.00	06000	LABORATORY	-7,911	2,647,721	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	751,358	65.00
65.01	06501	SLEEP LAB	0	186,746	65.01
66.00	06600	PHYSICAL THERAPY	0	880,546	66.00
69.00	06900	ELECTROCARDIOLOGY	0	340,647	69.00
69.01	06901	CARDIAC REHAB	0	71,645	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	441,972	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	651,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	171,636	76.00
76.01	03480	ONCOLOGY	0	1,096,544	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	171,148	90.00
90.01	09001	CLINIC- MCDONALD	-1,054,459	350,894	90.01
91.00	09100	EMERGENCY	0	2,143,281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	638,640	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	0	146,375	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,252,139	50,906,731	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	194.00
194.01	07951	MOB	0	35,416	194.01
194.02	07952	COMMUNITY HEALTH	0	84,595	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	194.03
194.04	07954	EDUCATION	0	27,500	194.04
194.05	07955	MARKETING	0	427,669	194.05
194.06	07956	GUEST MEALS	0	38,575	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	194.07
194.08	07958	CANCER CENTER	0	0	194.08
194.09	07959	URGENT CARE	0	1,422,378	194.09
194.10	07960	RHC	0	695,802	194.10
194.11	07961	OBGYN	0	81,013	194.11
194.12	07962	TRINE STUDENT HEALTH	0	15,693	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	152,829	194.13
194.14	07964	IMMUNIZATION CLINIC	0	58,590	194.14
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,252,139	53,946,791	200.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/22/2018 11:52 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	453,614	95,240	1.00
2.00	NURSERY	43.00	45,349	9,521	2.00
3.00	EMERGENCY	91.00	1,345	282	3.00
	0		500,308	105,043	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	89,727	1.00
	0		0	89,727	
	C - CAFERTERIA				
1.00	CAFETERIA	11.00	312,128	277,623	1.00
2.00	GUEST MEALS	194.06	20,416	18,159	2.00
	0		332,544	295,782	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,609,358	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	26,663	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	61,815	3.00
	0		0	1,697,836	
	E - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,202,664	1.00
	0		0	2,202,664	
	F - ICU				
1.00	INTENSIVE CARE UNIT	31.00	117,518	78,379	1.00
	0		117,518	78,379	
	G - ADVERTISING COST				
1.00	ADMINISTRATIVE & GENERAL	5.00	22,329	84,776	1.00
	0		22,329	84,776	
	H - PROPERTY TAX				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	17,716	1.00
	0		0	17,716	
	I - EDUCATION COSTS				
1.00	ADMINISTRATIVE & GENERAL	5.00	94,461	72,284	1.00
	0		94,461	72,284	
	J - SLEEP LAB				
1.00	SLEEP LAB	65.01	0	186,746	1.00
2.00		0.00	0	0	2.00
	0		0	186,746	
	K - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	32,915	1.00
2.00		0.00	0	0	2.00
	0		0	32,915	
	L - PUBLIC RELATIONS				
1.00	MARKETING	194.05	0	3,011	1.00
	0		0	3,011	
	M - HOME HEALTH SALARY				
1.00	HOME HEALTH AGENCY	101.00	19,941	0	1.00
	0		19,941	0	
	N - RECOVERY ROOM				
1.00	RECOVERY ROOM	51.00	687,058	0	1.00
	0		687,058	0	
	O - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	651,273	1.00
	0		0	651,273	
	P - HOME HEALTH ADMIN				
1.00	ADMINISTRATIVE & GENERAL	5.00	113,440	0	1.00
	0		113,440	0	
	Q - URGENT CARE				
1.00	ADMINISTRATIVE & GENERAL	5.00	160,782	0	1.00
	0		160,782	0	
	R - HOSPICE RECLASS				
1.00	HOSPICE	116.00	50,003	0	1.00
	0		50,003	0	
	S - DR. MCDONALD RECLASS				
1.00	MOB	194.01	29,499	5,917	1.00
	TOTALS		29,499	5,917	
500.00	Grand Total: Increases		2,127,883	5,524,069	500.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/22/2018 11:52 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - LABOR AND DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	500,308	105,043	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		500,308	105,043		
	B - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	89,727	12	1.00
	0		0	89,727		
	C - CAFERTERIA					
1.00	DIETARY	10.00	332,544	295,782	0	1.00
2.00		0.00	0	0	0	2.00
	0		332,544	295,782		
	D - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	1,697,836	9	1.00
2.00		0.00	0	0	10	2.00
3.00		0.00	0	0	0	3.00
	0		0	1,697,836		
	E - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,202,664	9	1.00
	0		0	2,202,664		
	F - ICU					
1.00	ADULTS & PEDIATRICS	30.00	117,518	78,379	0	1.00
	0		117,518	78,379		
	G - ADVERTISING COST					
1.00	MARKETING	194.05	22,329	84,776	0	1.00
	0		22,329	84,776		
	H - PROPERTY TAX					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,716	13	1.00
	0		0	17,716		
	I - EDUCATION COSTS					
1.00	EDUCATION	194.04	94,461	72,284	0	1.00
	0		94,461	72,284		
	J - SLEEP LAB					
1.00	RESPIRATORY THERAPY	65.00	0	160,309	0	1.00
2.00	ELECTROCARDIOLOGY	69.00	0	26,437	0	2.00
	0		0	186,746		
	K - UTILITIES					
1.00	MOB	194.01	0	21,039	0	1.00
2.00	RHC	194.10	0	11,876	0	2.00
	0		0	32,915		
	L - PUBLIC RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,011	0	1.00
	0		0	3,011		
	M - HOME HEALTH SALARY					
1.00	HOSPICE	116.00	19,941	0	0	1.00
	0		19,941	0		
	N - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	687,058	0	0	1.00
	0		687,058	0		
	O - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	651,273	0	1.00
	0		0	651,273		
	P - HOME HEALTH ADMIN					
1.00	HOME HEALTH AGENCY	101.00	113,440	0	0	1.00
	0		113,440	0		
	Q - URGENT CARE					
1.00	URGENT CARE	194.09	160,782	0	0	1.00
	0		160,782	0		
	R - HOSPICE RECLASS					
1.00	HOME HEALTH AGENCY	101.00	50,003	0	0	1.00
	0		50,003	0		
	S - DR. MCDONALD RECLASS					
1.00	CLINIC- MCDONALD	90.01	29,499	5,917	0	1.00
	TOTALS		29,499	5,917		
500.00	Grand Total: Decreases		2,127,883	5,524,069		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/22/2018 11:52 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,317,868	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	56,605,523	1,875,903	0	1,875,903	1,714,694	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	17,241,107	2,134,333	0	2,134,333	471,216	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	75,164,498	4,010,236	0	4,010,236	2,185,910	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	75,164,498	4,010,236	0	4,010,236	2,185,910	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,317,868	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	56,766,732	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	18,904,224	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,988,824	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	76,988,824	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/22/2018 11:52 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	6,040,550	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,760,756	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,040,550	1,760,756	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	6,040,550	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,760,756	2.00
3.00	Total (sum of lines 1-2)	0	7,801,306	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/22/2018 11:52 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	58,084,600	0	58,084,600	0.754455	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,904,224	0	18,904,224	0.245545	0	2.00
3.00	Total (sum of lines 1-2)	76,988,824	0	76,988,824	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,416,173	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,045,395	1,787,419	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,461,568	1,787,419	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-602,839	89,727	17,716	0	4,920,777	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-9,988	0	0	0	3,822,826	2.00
3.00	Total (sum of lines 1-2)	-612,827	89,727	17,716	0	8,743,603	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/22/2018 11:52 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-602,839	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-9,988	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	A	-23,155	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-11,386	CAP REL COSTS-MVBLE EQUIP	2.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,600,435			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	-554,600			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-287,489	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-86,222	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-401	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-14,984	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant	A	-168,988	CLINIC- MCDONALD	90.01	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-18,814	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	LOBBYING EXPENSES	A	-4,009	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8 Date/Time Prepared: 2/22/2018 11:52 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	EMPLOYEE CHRISTMAS PARTY	A	-14,018	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN RECRUITMENT	A	-103,357	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MEALS ON WHEELS	B	-13,741	DIETARY	10.00	0	33.03
33.04	RENTAL INCOME OFFSET - CANCER CENTER	B	-31,071	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	ATM SURCHARGE REVENUE	B	-449	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	OP EDUCATION	B	-240	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	DIETICIAN CONSULTATIONS	B	-3,280	CAFETERIA	11.00	0	33.07
33.09	HAF EXPENSE	B	-1,234,617	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PHYSICIAN INCOME GUARANTEE OFFSET	A	-468,056	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,252,139				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/22/2018 11:52 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO OVERHEAD - BENEFITS	0	393,931	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	0	30,300	2.00
3.00	7.00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	0	3,300	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	RENT PAID TO CMO	490,618	617,687	4.00
5.00	0		0	490,618	1,045,218	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office 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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	C	CAMERON MEDICAL	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/22/2018 11:52 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	-393,931	0	1.00
2.00	-30,300	0	2.00
3.00	-3,300	0	3.00
4.00	-127,069	9	4.00
5.00	-554,600		5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/22/2018 11:52 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	18,000	7,911	10,089	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	893,313	851,709	41,604	0	0	2.00
3.00	50.00	OPERATING ROOM	633,019	633,019	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	222,325	222,325	0	0	0	4.00
5.00	90.01	CLINIC- MCDONALD	885,471	885,471	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,652,128	2,600,435	51,693		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	90.01	CLINIC- MCDONALD	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	7,911		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	851,709		2.00
3.00	50.00	OPERATING ROOM	0	0	0	633,019		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	222,325		4.00
5.00	90.01	CLINIC- MCDONALD	0	0	0	885,471		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,600,435		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/22/2018 11:52 am

Respiratory Therapy | Cost

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

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	2,062.00	18,960.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	64.53	64.53	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.27	32.27	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	133,061	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	1,223,537	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	1,356,598	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	1,356,598	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	1,356,598	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	11,779	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	11,779	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,186	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	12,965	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/22/2018 11:52 am

Respiratory Therapy | Cost

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	16.25	398.75	0.00	0.00	16.25	47.00
48.00	Overtime rate (see instructions)	96.80	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	1,573.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	64.53	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	134,222	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	1,573	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	1,049	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	524	0	0	0	524	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	1,356,598	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	524	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	1,357,122	63.00
64.00	Total cost of outside supplier services (from your records)	654,441	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	11,779	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,186	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	12,965	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,186	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,186	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,920,777	4,920,777				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,822,826		3,822,826			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,274,350	25,391	15,972	6,315,713		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,523,264	435,341	366,684	1,215,625	10,540,914	5.00
7.00	00700	OPERATION OF PLANT	2,524,591	442,312	345,379	230,325	3,542,607	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,385	45,703	28,750	0	107,838	8.00
9.00	00900	HOUSEKEEPING	1,017,323	20,399	12,832	189,423	1,239,977	9.00
10.00	01000	DIETARY	161,692	168,783	106,175	27,949	464,599	10.00
11.00	01100	CAFETERIA	283,998	85,424	53,737	93,957	517,116	11.00
13.00	01300	NURSING ADMINISTRATION	677,976	35,116	22,090	189,810	924,992	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	261,257	134,097	84,355	51,352	531,061	14.00
15.00	01500	PHARMACY	2,764,128	49,705	31,268	132,085	2,977,186	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	666,563	0	29,968	129,430	825,961	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,746,120	695,225	437,340	727,280	4,605,965	30.00
31.00	03100	INTENSIVE CARE UNIT	195,897	50,781	31,944	35,375	313,997	31.00
43.00	04300	NURSERY	54,870	18,075	11,370	13,651	97,966	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,744,993	467,789	294,268	327,607	2,834,657	50.00
51.00	05100	RECOVERY ROOM	687,058	305,849	192,397	206,818	1,392,122	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	371,782	145,587	91,583	92,494	701,446	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,483,455	355,253	223,476	478,319	3,540,503	54.00
60.00	06000	LABORATORY	2,647,721	119,379	75,096	271,696	3,113,892	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	751,358	57,882	36,411	11,870	857,521	65.00
65.01	06501	SLEEP LAB	186,746	0	70,386	0	257,132	65.01
66.00	06600	PHYSICAL THERAPY	880,546	261,351	164,405	255,232	1,561,534	66.00
69.00	06900	ELECTROCARDIOLOGY	340,647	6,154	3,871	0	350,672	69.00
69.01	06901	CARDIAC REHAB	71,645	31,372	19,735	20,341	143,093	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	441,972	0	0	1	441,973	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	651,273	0	0	0	651,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	171,636	0	0	30,695	202,331	76.00
76.01	03480	ONCOLOGY	1,096,544	477,687	300,494	0	1,874,725	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	171,148	21,173	13,319	43,918	249,558	90.00
90.01	09001	CLINIC- MCDONALD	350,894	0	103,901	136,902	591,697	90.01
91.00	09100	EMERGENCY	2,143,281	410,725	258,371	523,130	3,335,507	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	638,640	0	39,768	170,946	849,354	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	146,375	0	8,149	35,111	189,635	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,906,731	4,866,553	3,473,494	5,641,342	49,828,804	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,960	15,701	0	40,661	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	35,416	0	0	8,880	44,296	194.01
194.02	07952	COMMUNITY HEALTH	84,595	0	0	23,302	107,897	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	27,500	0	0	0	27,500	194.04
194.05	07955	MARKETING	427,669	29,264	18,409	34,227	509,569	194.05
194.06	07956	GUEST MEALS	38,575	0	0	6,146	44,721	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	1,422,378	0	170,199	343,629	1,936,206	194.09
194.10	07960	RHC	695,802	0	118,817	181,320	995,939	194.10
194.11	07961	OBGYN	81,013	0	0	21,170	102,183	194.11
194.12	07962	TRINE STUDENT HEALTH	15,693	0	0	4,479	20,172	194.12
194.13	07963	OCCUPATIONAL HEALTH	152,829	0	22,930	33,930	209,689	194.13
194.14	07964	IMMUNIZATION CLINIC	58,590	0	3,276	17,288	79,154	194.14
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)	53,946,791	4,920,777	3,822,826	6,315,713	53,946,791	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,540,914					5.00
7.00	00700	OPERATION OF PLANT	860,304	4,402,911				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,188	40,902	174,928			8.00
9.00	00900	HOUSEKEEPING	301,122	18,256	46,702	1,606,057		9.00
10.00	01000	DIETARY	112,826	151,053	147	8,737	737,362	10.00
11.00	01100	CAFETERIA	125,579	76,451	1,046	61,162	0	11.00
13.00	01300	NURSING ADMINISTRATION	224,630	31,428	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128,966	120,010	0	11,468	0	14.00
15.00	01500	PHARMACY	722,995	44,484	0	15,018	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	200,580	42,635	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,118,549	622,196	33,808	448,887	688,862	30.00
31.00	03100	INTENSIVE CARE UNIT	76,253	45,447	1,868	16,929	48,500	31.00
43.00	04300	NURSERY	23,791	16,176	5,842	87,102	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	688,382	418,650	31,806	118,229	0	50.00
51.00	05100	RECOVERY ROOM	338,070	273,721	0	77,272	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	170,343	130,294	1,660	17,475	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,793	317,935	14,853	118,775	0	54.00
60.00	06000	LABORATORY	756,193	106,839	398	77,545	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	208,245	51,802	21	15,837	0	65.00
65.01	06501	SLEEP LAB	62,443	100,137	2,327	21,571	0	65.01
66.00	06600	PHYSICAL THERAPY	379,211	233,897	3,819	55,155	0	66.00
69.00	06900	ELECTROCARDIOLOGY	85,159	5,508	0	0	0	69.00
69.01	06901	CARDIAC REHAB	34,749	28,077	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,331	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,158	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	49,135	0	0	0	0	76.00
76.01	03480	ONCOLOGY	455,268	427,508	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	60,604	18,949	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	143,691	147,818	1,444	73,722	0	90.01
91.00	09100	EMERGENCY	810,011	367,580	27,826	242,738	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	206,261	56,577	0	15,837	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	46,052	11,593	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,540,882	3,905,923	173,567	1,483,459	737,362	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,874	22,338	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	10,757	0	131	6,826	0	194.01
194.02	07952	COMMUNITY HEALTH	26,202	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	6,678	0	0	0	0	194.04
194.05	07955	MARKETING	123,746	26,190	0	0	0	194.05
194.06	07956	GUEST MEALS	10,860	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	470,198	242,139	1,230	76,999	0	194.09
194.10	07960	RHC	241,859	169,039	0	38,773	0	194.10
194.11	07961	OBGYN	24,815	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	4,899	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	50,922	32,622	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	19,222	4,660	0	0	0	194.14
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)	10,540,914	4,402,911	174,928	1,606,057	737,362	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	781,354					11.00
13.00	01300	NURSING ADMINISTRATION	28,895	1,209,945				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,727	0	808,232			14.00
15.00	01500	PHARMACY	18,340	0	4,465	3,782,488		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,820	0	111	0	1,106,107	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	152,645	472,113	33,927	0	10,565	30.00
31.00	03100	INTENSIVE CARE UNIT	7,820	24,160	2,032	0	1,263	31.00
43.00	04300	NURSERY	2,209	6,863	0	0	2,063	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,313	192,795	105,867	0	30,212	50.00
51.00	05100	RECOVERY ROOM	37,697	116,566	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,044	46,495	12,417	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,090	0	11,961	0	234,321	54.00
60.00	06000	LABORATORY	69,046	0	257,717	0	307,383	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,333	0	6,615	0	35,610	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	49,163	0	2,922	0	123,427	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	828	0	63,949	69.00
69.01	06901	CARDIAC REHAB	3,787	0	114	0	31,906	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	122,402	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	180,367	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,782,488	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	8,521	0	1,150	0	1,368	76.00
76.01	03480	ONCOLOGY	0	0	6	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	9,643	29,776	5,629	0	40,041	90.00
90.01	09001	CLINIC- MCDONALD	20,619	0	2,345	0	36,222	90.01
91.00	09100	EMERGENCY	103,832	321,177	43,141	0	159,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	29,105	0	1,623	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	8,030	0	328	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	765,679	1,209,945	795,967	3,782,488	1,077,453	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	1,859	0	0	0	26,591	194.01
194.02	07952	COMMUNITY HEALTH	3,647	0	571	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	7,855	0	94	0	0	194.05
194.06	07956	GUEST MEALS	2,314	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	5,463	0	0	194.09
194.10	07960	RHC	0	0	4,478	0	0	194.10
194.11	07961	OBGYN	0	0	675	0	2,063	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	144	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	646	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	194	0	0	194.14
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)	781,354	1,209,945	808,232	3,782,488	1,106,107	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	8,187,517	0	8,187,517	30.00
31.00	03100	INTENSIVE CARE UNIT	538,269	0	538,269	31.00
43.00	04300	NURSERY	242,012	0	242,012	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,482,911	0	4,482,911	50.00
51.00	05100	RECOVERY ROOM	2,235,448	0	2,235,448	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,095,174	0	1,095,174	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,182,231	0	5,182,231	54.00
60.00	06000	LABORATORY	4,689,013	0	4,689,013	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,176,984	0	1,176,984	65.00
65.01	06501	SLEEP LAB	443,610	0	443,610	65.01
66.00	06600	PHYSICAL THERAPY	2,409,128	0	2,409,128	66.00
69.00	06900	ELECTROCARDIOLOGY	506,116	0	506,116	69.00
69.01	06901	CARDIAC REHAB	241,726	0	241,726	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	671,706	0	671,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	989,798	0	989,798	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,782,488	0	3,782,488	73.00
76.00	03020	CHEMICAL DEPENDENCY	262,505	0	262,505	76.00
76.01	03480	ONCOLOGY	2,757,507	0	2,757,507	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	414,200	0	414,200	90.00
90.01	09001	CLINIC- MCDONALD	1,017,558	0	1,017,558	90.01
91.00	09100	EMERGENCY	5,410,935	0	5,410,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	1,158,757	0	1,158,757	101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	255,638	0	255,638	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,151,231	0	48,151,231	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72,873	0	72,873	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	194.00
194.01	07951	MOB	90,460	0	90,460	194.01
194.02	07952	COMMUNITY HEALTH	138,317	0	138,317	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	194.03
194.04	07954	EDUCATION	34,178	0	34,178	194.04
194.05	07955	MARKETING	667,454	0	667,454	194.05
194.06	07956	GUEST MEALS	57,895	0	57,895	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	194.08
194.09	07959	URGENT CARE	2,732,235	0	2,732,235	194.09
194.10	07960	RHC	1,450,088	0	1,450,088	194.10
194.11	07961	OBGYN	129,736	0	129,736	194.11
194.12	07962	TRINE STUDENT HEALTH	25,215	0	25,215	194.12
194.13	07963	OCCUPATIONAL HEALTH	293,879	0	293,879	194.13
194.14	07964	IMMUNIZATION CLINIC	103,230	0	103,230	194.14
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)	53,946,791	0	53,946,791	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	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	25,391	15,972	41,363	41,363	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	435,341	366,684	802,025	7,971	5.00
7.00	00700	OPERATION OF PLANT	0	442,312	345,379	787,691	1,508	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,703	28,750	74,453	0	8.00
9.00	00900	HOUSEKEEPING	0	20,399	12,832	33,231	1,240	9.00
10.00	01000	DIETARY	0	168,783	106,175	274,958	183	10.00
11.00	01100	CAFETERIA	0	85,424	53,737	139,161	615	11.00
13.00	01300	NURSING ADMINISTRATION	0	35,116	22,090	57,206	1,243	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	134,097	84,355	218,452	336	14.00
15.00	01500	PHARMACY	0	49,705	31,268	80,973	865	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	29,968	29,968	847	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	695,225	437,340	1,132,565	4,762	30.00
31.00	03100	INTENSIVE CARE UNIT	0	50,781	31,944	82,725	232	31.00
43.00	04300	NURSERY	0	18,075	11,370	29,445	89	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	467,789	294,268	762,057	2,145	50.00
51.00	05100	RECOVERY ROOM	0	305,849	192,397	498,246	1,354	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	145,587	91,583	237,170	606	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	355,253	223,476	578,729	3,132	54.00
60.00	06000	LABORATORY	0	119,379	75,096	194,475	1,779	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	57,882	36,411	94,293	78	65.00
65.01	06501	SLEEP LAB	0	0	70,386	70,386	0	65.01
66.00	06600	PHYSICAL THERAPY	0	261,351	164,405	425,756	1,671	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,154	3,871	10,025	0	69.00
69.01	06901	CARDIAC REHAB	0	31,372	19,735	51,107	133	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	201	76.00
76.01	03480	ONCOLOGY	0	477,687	300,494	778,181	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	21,173	13,319	34,492	288	90.00
90.01	09001	CLINIC- MCDONALD	0	0	103,901	103,901	896	90.01
91.00	09100	EMERGENCY	0	410,725	258,371	669,096	3,425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	39,768	39,768	1,119	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	8,149	8,149	230	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,866,553	3,473,494	8,340,047	36,948	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,960	15,701	40,661	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	58	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	153	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	29,264	18,409	47,673	224	194.05
194.06	07956	GUEST MEALS	0	0	0	0	40	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	170,199	170,199	2,250	194.09
194.10	07960	RHC	0	0	118,817	118,817	1,187	194.10
194.11	07961	OBGYN	0	0	0	0	139	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	29	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	22,930	22,930	222	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	3,276	3,276	113	194.14
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,920,777	3,822,826	8,743,603	41,363	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	809,996					5.00
7.00	00700	OPERATION OF PLANT	66,109	855,308				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,012	7,946	84,411			8.00
9.00	00900	HOUSEKEEPING	23,139	3,546	22,534	83,690		9.00
10.00	01000	DIETARY	8,670	29,343	71	455	313,680	10.00
11.00	01100	CAFETERIA	9,650	14,851	505	3,187	0	11.00
13.00	01300	NURSING ADMINISTRATION	17,261	6,105	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,910	23,313	0	598	0	14.00
15.00	01500	PHARMACY	55,557	8,641	0	783	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,413	8,282	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	85,952	120,870	16,314	23,390	293,048	30.00
31.00	03100	INTENSIVE CARE UNIT	5,859	8,828	902	882	20,632	31.00
43.00	04300	NURSERY	1,828	3,142	2,819	4,539	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,898	81,327	15,348	6,161	0	50.00
51.00	05100	RECOVERY ROOM	25,978	53,173	0	4,027	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,090	25,311	801	911	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,069	61,762	7,167	6,189	0	54.00
60.00	06000	LABORATORY	58,108	20,754	192	4,041	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,002	10,063	10	825	0	65.00
65.01	06501	SLEEP LAB	4,798	19,453	1,123	1,124	0	65.01
66.00	06600	PHYSICAL THERAPY	29,140	45,437	1,843	2,874	0	66.00
69.00	06900	ELECTROCARDIOLOGY	6,544	1,070	0	0	0	69.00
69.01	06901	CARDIAC REHAB	2,670	5,454	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,248	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,153	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	3,776	0	0	0	0	76.00
76.01	03480	ONCOLOGY	34,984	83,048	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	4,657	3,681	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	11,042	28,715	697	3,842	0	90.01
91.00	09100	EMERGENCY	62,244	71,406	13,428	12,649	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15,850	10,991	0	825	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	3,539	2,252	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	733,150	758,764	83,754	77,302	313,680	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	759	4,339	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	827	0	63	356	0	194.01
194.02	07952	COMMUNITY HEALTH	2,013	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	513	0	0	0	0	194.04
194.05	07955	MARKETING	9,509	5,088	0	0	0	194.05
194.06	07956	GUEST MEALS	835	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	36,132	47,038	594	4,012	0	194.09
194.10	07960	RHC	18,585	32,837	0	2,020	0	194.10
194.11	07961	OBGYN	1,907	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	376	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	3,913	6,337	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	1,477	905	0	0	0	194.14
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)	809,996	855,308	84,411	83,690	313,680	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	167,969					11.00
13.00	01300	NURSING ADMINISTRATION	6,212	88,027				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,596	0	256,205			14.00
15.00	01500	PHARMACY	3,943	0	1,415	152,177		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,915	0	35	0	62,460	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,811	34,348	10,755	0	597	30.00
31.00	03100	INTENSIVE CARE UNIT	1,681	1,758	644	0	71	31.00
43.00	04300	NURSERY	475	499	0	0	116	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,396	14,026	33,559	0	1,706	50.00
51.00	05100	RECOVERY ROOM	8,104	8,480	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,234	3,383	3,936	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,077	0	3,791	0	13,232	54.00
60.00	06000	LABORATORY	14,843	0	81,695	0	17,358	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	286	0	2,097	0	2,011	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	10,569	0	926	0	6,970	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	262	0	3,611	69.00
69.01	06901	CARDIAC REHAB	814	0	36	0	1,802	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	38,801	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	57,175	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	152,177	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	1,832	0	365	0	77	76.00
76.01	03480	ONCOLOGY	0	0	2	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	2,073	2,166	1,785	0	2,261	90.00
90.01	09001	CLINIC- MCDONALD	4,433	0	743	0	2,045	90.01
91.00	09100	EMERGENCY	22,321	23,367	13,675	0	8,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,257	0	515	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,726	0	104	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	164,598	88,027	252,316	152,177	60,842	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	400	0	0	0	1,502	194.01
194.02	07952	COMMUNITY HEALTH	784	0	181	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	1,689	0	30	0	0	194.05
194.06	07956	GUEST MEALS	498	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	1,732	0	0	194.09
194.10	07960	RHC	0	0	1,419	0	0	194.10
194.11	07961	OBGYN	0	0	214	0	116	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	46	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	205	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	62	0	0	194.14
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)	167,969	88,027	256,205	152,177	62,460	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,755,412	0	1,755,412		30.00
31.00	03100	INTENSIVE CARE UNIT	124,214	0	124,214		31.00
43.00	04300	NURSERY	42,952	0	42,952		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	982,623	0	982,623		50.00
51.00	05100	RECOVERY ROOM	599,362	0	599,362		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	288,442	0	288,442		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	758,148	0	758,148		54.00
60.00	06000	LABORATORY	393,245	0	393,245		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	125,665	0	125,665		65.00
65.01	06501	SLEEP LAB	96,884	0	96,884		65.01
66.00	06600	PHYSICAL THERAPY	525,186	0	525,186		66.00
69.00	06900	ELECTROCARDIOLOGY	21,512	0	21,512		69.00
69.01	06901	CARDIAC REHAB	62,016	0	62,016		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,049	0	47,049		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,328	0	69,328		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	152,177	0	152,177		73.00
76.00	03020	CHEMICAL DEPENDENCY	6,251	0	6,251		76.00
76.01	03480	ONCOLOGY	896,215	0	896,215		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	51,403	0	51,403		90.00
90.01	09001	CLINIC- MCDONALD	156,314	0	156,314		90.01
91.00	09100	EMERGENCY	900,596	0	900,596		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	75,325	0	75,325		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	16,000	0	16,000		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,146,319	0	8,146,319		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,759	0	45,759		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	3,206	0	3,206		194.01
194.02	07952	COMMUNITY HEALTH	3,131	0	3,131		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	513	0	513		194.04
194.05	07955	MARKETING	64,213	0	64,213		194.05
194.06	07956	GUEST MEALS	1,373	0	1,373		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	261,957	0	261,957		194.09
194.10	07960	RHC	174,865	0	174,865		194.10
194.11	07961	OBGYN	2,376	0	2,376		194.11
194.12	07962	TRINE STUDENT HEALTH	451	0	451		194.12
194.13	07963	OCCUPATIONAL HEALTH	33,607	0	33,607		194.13
194.14	07964	IMMUNIZATION CLINIC	5,833	0	5,833		194.14
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	8,743,603	0	8,743,603		202.00

		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	114,344					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		141,212				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	590	590	20,981,024			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,116	13,545	4,038,335	-10,540,914	43,405,877	5.00
7.00	00700	OPERATION OF PLANT	10,278	12,758	765,147	0	3,542,607	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,062	0	0	107,838	8.00
9.00	00900	HOUSEKEEPING	474	474	629,272	0	1,239,977	9.00
10.00	01000	DIETARY	3,922	3,922	92,848	0	464,599	10.00
11.00	01100	CAFETERIA	1,985	1,985	312,128	0	517,116	11.00
13.00	01300	NURSING ADMINISTRATION	816	816	630,555	0	924,992	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	3,116	170,592	0	531,061	14.00
15.00	01500	PHARMACY	1,155	1,155	438,790	0	2,977,186	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,107	429,972	0	825,961	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,155	16,155	2,416,053	0	4,605,965	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	1,180	117,518	0	313,997	31.00
43.00	04300	NURSERY	420	420	45,349	0	97,966	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,870	10,870	1,088,324	0	2,834,657	50.00
51.00	05100	RECOVERY ROOM	7,107	7,107	687,058	0	1,392,122	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,383	3,383	307,268	0	701,446	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,255	8,255	1,588,994	0	3,540,503	54.00
60.00	06000	LABORATORY	2,774	2,774	902,585	0	3,113,892	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,345	1,345	39,433	0	857,521	65.00
65.01	06501	SLEEP LAB	0	2,600	0	0	257,132	65.01
66.00	06600	PHYSICAL THERAPY	6,073	6,073	847,890	0	1,561,534	66.00
69.00	06900	ELECTROCARDIOLOGY	143	143	0	0	350,672	69.00
69.01	06901	CARDIAC REHAB	729	729	67,574	0	143,093	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2	0	441,973	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	651,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	101,970	0	202,331	76.00
76.01	03480	ONCOLOGY	11,100	11,100	0	0	1,874,725	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	492	492	145,896	0	249,558	90.00
90.01	09001	CLINIC- MCDONALD	0	3,838	454,795	0	591,697	90.01
91.00	09100	EMERGENCY	9,544	9,544	1,737,859	0	3,335,507	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,469	567,890	0	849,354	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	301	116,641	0	189,635	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,084	128,308	18,740,738	-10,540,914	39,287,890	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	580	0	0	40,661	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	29,499	0	44,296	194.01
194.02	07952	COMMUNITY HEALTH	0	0	77,410	0	107,897	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	27,500	194.04
194.05	07955	MARKETING	680	680	113,703	0	509,569	194.05
194.06	07956	GUEST MEALS	0	0	20,416	0	44,721	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	6,287	1,141,550	0	1,936,206	194.09
194.10	07960	RHC	0	4,389	602,353	0	995,939	194.10
194.11	07961	OBGYN	0	0	70,328	0	102,183	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	14,879	0	20,172	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	847	112,718	0	209,689	194.13
194.14	07964	IMMUNIZATION CLINIC	0	121	57,430	0	79,154	194.14
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/22/2018 11:52 am

	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	
202.00	Cost to be allocated (per Wkst. B, Part I)	4,920,777	3,822,826	6,315,713		10,540,914	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	43.034851	27.071538	0.301020		0.242845	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			41,363		809,996	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001971		0.018661	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	114,319					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	65,542				8.00
9.00	00900	HOUSEKEEPING	474	17,498	5,882			9.00
10.00	01000	DIETARY	3,922	55	32	14,276		10.00
11.00	01100	CAFETERIA	1,985	392	224	0	22,282	11.00
13.00	01300	NURSING ADMINISTRATION	816	0	0	0	824	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	0	42	0	477	14.00
15.00	01500	PHARMACY	1,155	0	55	0	523	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,107	0	0	0	1,050	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,155	12,667	1,644	13,337	4,353	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	700	62	939	223	31.00
43.00	04300	NURSERY	420	2,189	319	0	63	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,870	11,917	433	0	1,777	50.00
51.00	05100	RECOVERY ROOM	7,107	0	283	0	1,075	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,383	622	64	0	429	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,255	5,565	435	0	2,398	54.00
60.00	06000	LABORATORY	2,774	149	284	0	1,969	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,345	8	58	0	38	65.00
65.01	06501	SLEEP LAB	2,600	872	79	0	0	65.01
66.00	06600	PHYSICAL THERAPY	6,073	1,431	202	0	1,402	66.00
69.00	06900	ELECTROCARDIOLOGY	143	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	729	0	0	0	108	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	243	76.00
76.01	03480	ONCOLOGY	11,100	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	492	0	0	0	275	90.00
90.01	09001	CLINIC- MCDONALD	3,838	541	270	0	588	90.01
91.00	09100	EMERGENCY	9,544	10,426	889	0	2,961	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,469	0	58	0	830	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	301	0	0	0	229	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,415	65,032	5,433	14,276	21,835	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	49	25	0	53	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	104	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	680	0	0	0	224	194.05
194.06	07956	GUEST MEALS	0	0	0	0	66	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	6,287	461	282	0	0	194.09
194.10	07960	RHC	4,389	0	142	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	847	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	121	0	0	0	0	194.14
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,402,911	174,928	1,606,057	737,362	781,354	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.514254	2.668945	273.046073	51.650462	35.066601	203.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet B-1 Date/Time Prepared: 2/22/2018 11:52 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	855,308	84,411	83,690	313,680	167,969	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	7.481766	1.287892	14.228154	21.972541	7.538327	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	232,023					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,918,389				14.00
15.00	01500	PHARMACY	0	16,123	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	400	0	674,532		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,534	122,503	0	6,443		30.00
31.00	03100	INTENSIVE CARE UNIT	4,633	7,336	0	770		31.00
43.00	04300	NURSERY	1,316	0	0	1,258		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,971	382,268	0	18,424		50.00
51.00	05100	RECOVERY ROOM	22,353	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,916	44,834	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,188	0	142,895		54.00
60.00	06000	LABORATORY	0	930,579	0	187,450		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	23,885	0	21,716		65.00
65.01	06501	SLEEP LAB	0	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	10,552	0	75,269		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,990	0	38,998		69.00
69.01	06901	CARDIAC REHAB	0	410	0	19,457		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	441,972	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	651,273	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	4,153	0	834		76.00
76.01	03480	ONCOLOGY	0	23	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	5,710	20,327	0	24,418		90.00
90.01	09001	CLINIC- MCDONALD	0	8,468	0	22,089		90.01
91.00	09100	EMERGENCY	61,590	155,775	0	97,037		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,861	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,186	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	232,023	2,874,106	100	657,058		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	16,216		194.01
194.02	07952	COMMUNITY HEALTH	0	2,060	0	0		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0	0		194.04
194.05	07955	MARKETING	0	338	0	0		194.05
194.06	07956	GUEST MEALS	0	0	0	0		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0	0		194.08
194.09	07959	URGENT CARE	0	19,726	0	0		194.09
194.10	07960	RHC	0	16,169	0	0		194.10
194.11	07961	OBGYN	0	2,436	0	1,258		194.11
194.12	07962	TRINE STUDENT HEALTH	0	520	0	0		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	2,333	0	0		194.13
194.14	07964	IMMUNIZATION CLINIC	0	701	0	0		194.14
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)	1,209,945	808,232	3,782,488	1,106,107		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.214763	0.276945	37,824.880000	1.639814		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 Date/Time Prepared: 2/22/2018 11:52 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	88,027	256,205	152,177	62,460		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.379389	0.087790	1,521.770000	0.092598		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,187,517		8,187,517	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	538,269		538,269	0	0	31.00
43.00	04300	NURSERY	242,012		242,012	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,482,911		4,482,911	0	0	50.00
51.00	05100	RECOVERY ROOM	2,235,448		2,235,448	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,095,174		1,095,174	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,182,231		5,182,231	0	0	54.00
60.00	06000	LABORATORY	4,689,013		4,689,013	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,176,984	0	1,176,984	0	0	65.00
65.01	06501	SLEEP LAB	443,610	0	443,610	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,409,128	0	2,409,128	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	506,116		506,116	0	0	69.00
69.01	06901	CARDIAC REHAB	241,726		241,726	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	671,706		671,706	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	989,798		989,798	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,782,488		3,782,488	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	262,505		262,505	0	0	76.00
76.01	03480	ONCOLOGY	2,757,507		2,757,507	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	414,200		414,200	0	0	90.00
90.01	09001	CLINIC- MCDONALD	1,017,558		1,017,558	0	0	90.01
91.00	09100	EMERGENCY	5,410,935		5,410,935	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,380,886		2,380,886		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,158,757		1,158,757		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	255,638		255,638		0	116.00
200.00		Subtotal (see instructions)	50,532,117	0	50,532,117	0	0	200.00
201.00		Less Observation Beds	2,380,886		2,380,886		0	201.00
202.00		Total (see instructions)	48,151,231	0	48,151,231	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	6,977,139		6,977,139			30.00
31.00	03100	INTENSIVE CARE UNIT	432,414		432,414			31.00
43.00	04300	NURSERY	407,000		407,000			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,177,846	13,202,102	15,379,948	0.291478	0.000000	50.00
51.00	05100	RECOVERY ROOM	441,592	3,042,009	3,483,601	0.641706	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	657,035	146,157	803,192	1.363527	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,328,528	27,502,253	28,830,781	0.179746	0.000000	54.00
60.00	06000	LABORATORY	1,767,027	11,339,741	13,106,768	0.357755	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,294,644	944,224	2,238,868	0.525705	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,099,933	1,099,933	0.403306	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	649,963	3,718,986	4,368,949	0.551420	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	175,778	1,769,416	1,945,194	0.260188	0.000000	69.00
69.01	06901	CARDIAC REHAB	10,583	380,379	390,962	0.618285	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	473,864	2,068,503	2,542,367	0.264205	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	489,634	855,038	1,344,672	0.736089	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,484,190	7,856,978	9,341,168	0.404927	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	73,532	73,532	3.569942	0.000000	76.00
76.01	03480	ONCOLOGY	0	6,608,615	6,608,615	0.417259	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	497,298	497,298	0.832901	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	0	140,972	140,972	7.218157	0.000000	90.01
91.00	09100	EMERGENCY	463,423	14,404,731	14,868,154	0.363928	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	113,382	1,760,014	1,873,396	1.270893	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	849,564	849,564			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	324,471	324,471			116.00
200.00		Subtotal (see instructions)	19,344,042	98,584,916	117,928,958			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,344,042	98,584,916	117,928,958			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I | Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance (Costs)	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,187,517		8,187,517	0	8,187,517	30.00
31.00	03100	INTENSIVE CARE UNIT	538,269		538,269	0	538,269	31.00
43.00	04300	NURSERY	242,012		242,012	0	242,012	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,482,911		4,482,911	0	4,482,911	50.00
51.00	05100	RECOVERY ROOM	2,235,448		2,235,448	0	2,235,448	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,095,174		1,095,174	0	1,095,174	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,182,231		5,182,231	0	5,182,231	54.00
60.00	06000	LABORATORY	4,689,013		4,689,013	0	4,689,013	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,176,984	0	1,176,984	0	1,176,984	65.00
65.01	06501	SLEEP LAB	443,610	0	443,610	0	443,610	65.01
66.00	06600	PHYSICAL THERAPY	2,409,128	0	2,409,128	0	2,409,128	66.00
69.00	06900	ELECTROCARDIOLOGY	506,116		506,116	0	506,116	69.00
69.01	06901	CARDIAC REHAB	241,726		241,726	0	241,726	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	671,706		671,706	0	671,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	989,798		989,798	0	989,798	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,782,488		3,782,488	0	3,782,488	73.00
76.00	03020	CHEMICAL DEPENDENCY	262,505		262,505	0	262,505	76.00
76.01	03480	ONCOLOGY	2,757,507		2,757,507	0	2,757,507	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	414,200		414,200	0	414,200	90.00
90.01	09001	CLINIC- MCDONALD	1,017,558		1,017,558	0	1,017,558	90.01
91.00	09100	EMERGENCY	5,410,935		5,410,935	0	5,410,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,380,886		2,380,886		2,380,886	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,158,757		1,158,757		1,158,757	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	255,638		255,638		255,638	116.00
200.00		Subtotal (see instructions)	50,532,117	0	50,532,117	0	50,532,117	200.00
201.00		Less Observation Beds	2,380,886		2,380,886		2,380,886	201.00
202.00		Total (see instructions)	48,151,231	0	48,151,231	0	48,151,231	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1315

Period: From 10/01/2016 To 09/30/2017

Worksheet C Part I

Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	6,977,139		6,977,139			30.00
31.00	03100	INTENSIVE CARE UNIT	432,414		432,414			31.00
43.00	04300	NURSERY	407,000		407,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,177,846	13,202,102	15,379,948	0.291478	0.000000	50.00
51.00	05100	RECOVERY ROOM	441,592	3,042,009	3,483,601	0.641706	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	657,035	146,157	803,192	1.363527	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,328,528	27,502,253	28,830,781	0.179746	0.000000	54.00
60.00	06000	LABORATORY	1,767,027	11,339,741	13,106,768	0.357755	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,294,644	944,224	2,238,868	0.525705	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,099,933	1,099,933	0.403306	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	649,963	3,718,986	4,368,949	0.551420	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	175,778	1,769,416	1,945,194	0.260188	0.000000	69.00
69.01	06901	CARDIAC REHAB	10,583	380,379	390,962	0.618285	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	473,864	2,068,503	2,542,367	0.264205	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	489,634	855,038	1,344,672	0.736089	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,484,190	7,856,978	9,341,168	0.404927	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	73,532	73,532	3.569942	0.000000	76.00
76.01	03480	ONCOLOGY	0	6,608,615	6,608,615	0.417259	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	497,298	497,298	0.832901	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	0	140,972	140,972	7.218157	0.000000	90.01
91.00	09100	EMERGENCY	463,423	14,404,731	14,868,154	0.363928	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	113,382	1,760,014	1,873,396	1.270893	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	849,564	849,564			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	324,471	324,471			116.00
200.00		Subtotal (see instructions)	19,344,042	98,584,916	117,928,958			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,344,042	98,584,916	117,928,958			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I | Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.291478	50.00
51.00	05100	RECOVERY ROOM	0.641706	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.363527	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179746	54.00
60.00	06000	LABORATORY	0.357755	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.525705	65.00
65.01	06501	SLEEP LAB	0.403306	65.01
66.00	06600	PHYSICAL THERAPY	0.551420	66.00
69.00	06900	ELECTROCARDIOLOGY	0.260188	69.00
69.01	06901	CARDIAC REHAB	0.618285	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.264205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.736089	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404927	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.569942	76.00
76.01	03480	ONCOLOGY	0.417259	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.832901	90.00
90.01	09001	CLINIC- MCDONALD	7.218157	90.01
91.00	09100	EMERGENCY	0.363928	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.270893	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part II Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,482,911	982,623	3,500,288	0	0	50.00
51.00	05100	RECOVERY ROOM	2,235,448	599,362	1,636,086	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,095,174	288,442	806,732	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,182,231	758,148	4,424,083	0	0	54.00
60.00	06000	LABORATORY	4,689,013	393,245	4,295,768	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,176,984	125,665	1,051,319	0	0	65.00
65.01	06501	SLEEP LAB	443,610	96,884	346,726	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,409,128	525,186	1,883,942	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	506,116	21,512	484,604	0	0	69.00
69.01	06901	CARDIAC REHAB	241,726	62,016	179,710	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	671,706	47,049	624,657	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	989,798	69,328	920,470	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,782,488	152,177	3,630,311	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	262,505	6,251	256,254	0	0	76.00
76.01	03480	ONCOLOGY	2,757,507	896,215	1,861,292	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	414,200	51,403	362,797	0	0	90.00
90.01	09001	CLINIC- MCDONALD	1,017,558	156,314	861,244	0	0	90.01
91.00	09100	EMERGENCY	5,410,935	900,596	4,510,339	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,380,886	510,464	1,870,422	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,158,757	75,325	1,083,432	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	255,638	16,000	239,638	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	41,564,319	6,734,205	34,830,114	0	0	200.00
201.00		Less Observation Beds	2,380,886	510,464	1,870,422	0	0	201.00
202.00		Total (line 200 minus line 201)	39,183,433	6,223,741	32,959,692	0	0	202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part II | Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,482,911	15,379,948	0.291478	50.00
51.00	05100	RECOVERY ROOM	2,235,448	3,483,601	0.641706	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,095,174	803,192	1.363527	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,182,231	28,830,781	0.179746	54.00
60.00	06000	LABORATORY	4,689,013	13,106,768	0.357755	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,176,984	2,238,868	0.525705	65.00
65.01	06501	SLEEP LAB	443,610	1,099,933	0.403306	65.01
66.00	06600	PHYSICAL THERAPY	2,409,128	4,368,949	0.551420	66.00
69.00	06900	ELECTROCARDIOLOGY	506,116	1,945,194	0.260188	69.00
69.01	06901	CARDIAC REHAB	241,726	390,962	0.618285	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	671,706	2,542,367	0.264205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	989,798	1,344,672	0.736089	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,782,488	9,341,168	0.404927	73.00
76.00	03020	CHEMICAL DEPENDENCY	262,505	73,532	3.569942	76.00
76.01	03480	ONCOLOGY	2,757,507	6,608,615	0.417259	76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	89.00
90.00	09000	CLINIC	414,200	497,298	0.832901	90.00
90.01	09001	CLINIC- MCDONALD	1,017,558	140,972	7.218157	90.01
91.00	09100	EMERGENCY	5,410,935	14,868,154	0.363928	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,380,886	1,873,396	1.270893	92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,158,757	849,564	1.363943	101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	255,638	324,471	0.787861	116.00
200.00		Subtotal (sum of lines 50 thru 199)	41,564,319	110,112,405		200.00
201.00		Less Observation Beds	2,380,886	0		201.00
202.00		Total (line 200 minus line 201)	39,183,433	110,112,405		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	982,623	15,379,948	0.063890	681,395	43,534	50.00
51.00	05100	RECOVERY ROOM	599,362	3,483,601	0.172052	103,717	17,845	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	288,442	803,192	0.359120	3,873	1,391	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	758,148	28,830,781	0.026296	454,553	11,953	54.00
60.00	06000	LABORATORY	393,245	13,106,768	0.030003	598,094	17,945	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	125,665	2,238,868	0.056129	415,872	23,342	65.00
65.01	06501	SLEEP LAB	96,884	1,099,933	0.088082	0	0	65.01
66.00	06600	PHYSICAL THERAPY	525,186	4,368,949	0.120209	161,078	19,363	66.00
69.00	06900	ELECTROCARDIOLOGY	21,512	1,945,194	0.011059	166,405	1,840	69.00
69.01	06901	CARDIAC REHAB	62,016	390,962	0.158624	1,259	200	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,049	2,542,367	0.018506	320,578	5,933	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,328	1,344,672	0.051558	212,806	10,972	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	152,177	9,341,168	0.016291	487,672	7,945	73.00
76.00	03020	CHEMICAL DEPENDENCY	6,251	73,532	0.085011	0	0	76.00
76.01	03480	ONCOLOGY	896,215	6,608,615	0.135613	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	51,403	497,298	0.103365	0	0	90.00
90.01	09001	CLINIC- MCDONALD	156,314	140,972	1.108830	0	0	90.01
91.00	09100	EMERGENCY	900,596	14,868,154	0.060572	11,529	698	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	510,464	1,873,396	0.272481	94,478	25,743	92.00
200.00		Total (lines 50 through 199)	6,642,880	108,938,370		3,713,309	188,704	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	15,379,948	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,483,601	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	803,192	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,830,781	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,106,768	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,238,868	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,099,933	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,368,949	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,945,194	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	390,962	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,542,367	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,344,672	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,341,168	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	73,532	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	6,608,615	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	497,298	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	0	0	0	140,972	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	14,868,154	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,873,396	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	108,938,370		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	681,395	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	103,717	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,873	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	454,553	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	598,094	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	415,872	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	161,078	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	166,405	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	1,259	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	320,578	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	212,806	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	487,672	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	11,529	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	94,478	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,713,309	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.291478	0	3,392,146	0	0	50.00
51.00	05100	RECOVERY ROOM	0.641706	0	199,697	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.363527	0	2,184	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179746	0	6,678,583	0	0	54.00
60.00	06000	LABORATORY	0.357755	0	3,179,673	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.525705	0	523,825	0	0	65.00
65.01	06501	SLEEP LAB	0.403306	0	15,736	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.551420	0	1,153,272	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.260188	0	522,176	0	0	69.00
69.01	06901	CARDIAC REHAB	0.618285	0	142,584	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.264205	0	380,263	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.736089	0	232,459	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404927	0	2,599,070	13,040	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.569942	0	43,929	0	0	76.00
76.01	03480	ONCOLOGY	0.417259	0	2,487,045	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.832901	0	226,157	0	0	90.00
90.01	09001	CLINIC- MCDONALD	7.218157	0	67,792	0	0	90.01
91.00	09100	EMERGENCY	0.363928	0	2,931,776	3,145	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.270893	0	1,006,178	505	0	92.00
200.00		Subtotal (see instructions)		0	25,784,545	16,690	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	25,784,545	16,690	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	988,736	0	50.00
51.00	05100	RECOVERY ROOM	128,147	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,978	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,200,449	0	54.00
60.00	06000	LABORATORY	1,137,544	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	275,377	0	65.00
65.01	06501	SLEEP LAB	6,346	0	65.01
66.00	06600	PHYSICAL THERAPY	635,937	0	66.00
69.00	06900	ELECTROCARDIOLOGY	135,864	0	69.00
69.01	06901	CARDIAC REHAB	88,158	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100,467	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	171,111	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,052,434	5,280	73.00
76.00	03020	CHEMICAL DEPENDENCY	156,824	0	76.00
76.01	03480	ONCOLOGY	1,037,742	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	188,366	0	90.00
90.01	09001	CLINIC- MCDONALD	489,333	0	90.01
91.00	09100	EMERGENCY	1,066,955	1,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,278,745	642	92.00
200.00		Subtotal (see instructions)	10,141,513	7,067	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	10,141,513	7,067	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.291478	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.641706	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.363527	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179746	0	0	0	0	54.00
60.00	06000	LABORATORY	0.357755	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.525705	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.403306	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.551420	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.260188	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.618285	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.264205	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.736089	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404927	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.569942	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.417259	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.832901	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	7.218157	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.363928	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.270893	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Swing Beds - SNF | Cost

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I | Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,755,412	120,811	1,634,601	4,262	383.53	30.00
31.00	INTENSIVE CARE UNIT	124,214		124,214	206	602.98	31.00
43.00	NURSERY	42,952		42,952	406	105.79	43.00
200.00	Total (lines 30 through 199)	1,922,578		1,801,767	4,874		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	75	28,765	30.00
31.00	INTENSIVE CARE UNIT	19	11,457	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	94	40,222	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1315

Period: From 10/01/2016 To 09/30/2017

Worksheet D Part II

Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	982,623	15,379,948	0.063890	28,623	1,829	50.00
51.00	05100	RECOVERY ROOM	599,362	3,483,601	0.172052	5,804	999	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	288,442	803,192	0.359120	8,635	3,101	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	758,148	28,830,781	0.026296	17,461	459	54.00
60.00	06000	LABORATORY	393,245	13,106,768	0.030003	23,224	697	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	125,665	2,238,868	0.056129	17,015	955	65.00
65.01	06501	SLEEP LAB	96,884	1,099,933	0.088082	0	0	65.01
66.00	06600	PHYSICAL THERAPY	525,186	4,368,949	0.120209	8,542	1,027	66.00
69.00	06900	ELECTROCARDIOLOGY	21,512	1,945,194	0.011059	1,653	18	69.00
69.01	06901	CARDIAC REHAB	62,016	390,962	0.158624	139	22	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,049	2,542,367	0.018506	12,663	234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,328	1,344,672	0.051558	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	152,177	9,341,168	0.016291	19,507	318	73.00
76.00	03020	CHEMICAL DEPENDENCY	6,251	73,532	0.085011	0	0	76.00
76.01	03480	ONCOLOGY	896,215	6,608,615	0.135613	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	51,403	497,298	0.103365	0	0	90.00
90.01	09001	CLINIC- MCDONALD	156,314	140,972	1.108830	0	0	90.01
91.00	09100	EMERGENCY	900,596	14,868,154	0.060572	6,091	369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	512,395	1,873,396	0.273511	11,145	3,048	92.00
200.00		Total (lines 50 through 199)	6,644,811	108,938,370		160,502	13,076	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,262	0.00	75	30.00
31.00	03100	INTENSIVE CARE UNIT		0	206	0.00	19	31.00
43.00	04300	NURSERY		0	406	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	4,874		94	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	15,379,948	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,483,601	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	803,192	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,830,781	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,106,768	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,238,868	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,099,933	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,368,949	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,945,194	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	390,962	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,542,367	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,344,672	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,341,168	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	73,532	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	6,608,615	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	497,298	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	0	0	0	140,972	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	14,868,154	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,873,396	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	108,938,370		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	28,623	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	5,804	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	8,635	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	17,461	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	23,224	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	17,015	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	8,542	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,653	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	139	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	12,663	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	19,507	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	6,091	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	11,145	0	0	0	92.00
200.00		Total (lines 50 through 199)		160,502	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,776	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,262	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,926	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)	315	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)	199	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,103	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)	315	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	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.02	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,187,517	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)	30,849	25.00
26.00	Total swing-bed cost (see instructions)	592,211	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,595,306	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)	7,595,306	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)	1,782.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,965,656	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,965,656	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	538,269	206	2,612.96	79	206,424	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,480,728	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,652,808	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)	561,362	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	561,362	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,336	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,782.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,380,886	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,755,412	8,187,517	0.214401	2,380,886	510,464	90.00
91.00	Nursing School cost	0	8,187,517	0.000000	2,380,886	0	91.00
92.00	Allied health cost	0	8,187,517	0.000000	2,380,886	0	92.00
93.00	All other Medical Education	0	8,187,517	0.000000	2,380,886	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,776	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,262	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,926	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)	315	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)	199	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	75	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)	406	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)	8,187,517	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)	563,485	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,624,032	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)	7,624,032	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)	1,788.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	134,163	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)	134,163	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/22/2018 11:52 am
	Title XIX	Hospital	PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	242,012	406	596.09	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	538,269	206	2,612.96	19	49,646	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)	77,086	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	260,895	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)	40,222	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	13,076	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	53,298	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	207,597	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,336	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,788.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,389,890	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/22/2018 11:52 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,755,412	8,187,517	0.214401	2,389,890	512,395	90.00
91.00	Nursing School cost	0	8,187,517	0.000000	2,389,890	0	91.00
92.00	Allied health cost	0	8,187,517	0.000000	2,389,890	0	92.00
93.00	All other Medical Education	0	8,187,517	0.000000	2,389,890	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,603,053		30.00
31.00	03100	INTENSIVE CARE UNIT		165,900		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.291478	681,395	198,612	50.00
51.00	05100	RECOVERY ROOM	0.641706	103,717	66,556	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.363527	3,873	5,281	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179746	454,553	81,704	54.00
60.00	06000	LABORATORY	0.357755	598,094	213,971	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.525705	415,872	218,626	65.00
65.01	06501	SLEEP LAB	0.403306	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.551420	161,078	88,822	66.00
69.00	06900	ELECTROCARDIOLOGY	0.260188	166,405	43,297	69.00
69.01	06901	CARDIAC REHAB	0.618285	1,259	778	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.264205	320,578	84,698	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.736089	212,806	156,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404927	487,672	197,472	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.569942	0	0	76.00
76.01	03480	ONCOLOGY	0.417259	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.832901	0	0	90.00
90.01	09001	CLINIC- MCDONALD	7.218157	0	0	90.01
91.00	09100	EMERGENCY	0.363928	11,529	4,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.270893	94,478	120,071	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,713,309	1,480,728	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,713,309		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1315 Component CCN: 15-Z315	Period: From 10/01/2016 To 09/30/2017	Worksheet D-3 Date/Time Prepared: 2/22/2018 11:52 am
	Title XVIII	Swing Beds - SNF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.291478	1,033	301	50.00
51.00	05100	RECOVERY ROOM	0.641706	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.363527	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179746	12,869	2,313	54.00
60.00	06000	LABORATORY	0.357755	48,553	17,370	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.525705	21,711	11,414	65.00
65.01	06501	SLEEP LAB	0.403306	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.551420	198,318	109,357	66.00
69.00	06900	ELECTROCARDIOLOGY	0.260188	6,931	1,803	69.00
69.01	06901	CARDIAC REHAB	0.618285	1,439	890	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.264205	13,784	3,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.736089	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404927	59,561	24,118	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.569942	0	0	76.00
76.01	03480	ONCOLOGY	0.417259	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.832901	0	0	90.00
90.01	09001	CLINIC- MCDONALD	7.218157	0	0	90.01
91.00	09100	EMERGENCY	0.363928	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.270893	6,380	8,108	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		370,579	179,316	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)		370,579		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet D-3 Date/Time Prepared: 2/22/2018 11:52 am
	Title XIX	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		63,358		30.00
31.00	03100	INTENSIVE CARE UNIT		5,683		31.00
43.00	04300	NURSERY		5,349		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.291478	28,623	8,343	50.00
51.00	05100	RECOVERY ROOM	0.641706	5,804	3,724	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.363527	8,635	11,774	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179746	17,461	3,139	54.00
60.00	06000	LABORATORY	0.357755	23,224	8,309	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.525705	17,015	8,945	65.00
65.01	06501	SLEEP LAB	0.403306	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.551420	8,542	4,710	66.00
69.00	06900	ELECTROCARDIOLOGY	0.260188	1,653	430	69.00
69.01	06901	CARDIAC REHAB	0.618285	139	86	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.264205	12,663	3,346	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.736089	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.404927	19,507	7,899	73.00
76.00	03020	CHEMICAL DEPENDENCY	3.569942	0	0	76.00
76.01	03480	ONCOLOGY	0.417259	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.832901	0	0	90.00
90.01	09001	CLINIC- MCDONALD	7.218157	0	0	90.01
91.00	09100	EMERGENCY	0.363928	6,091	2,217	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.270893	11,145	14,164	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		160,502	77,086	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)		160,502		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part B Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,148,580	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	10,148,580	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 (line 11 minus line 20) (see instructions)	10,250,066	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 (for CAH, see instructions)	45,981	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,533,853	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,670,232	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,670,232	30.00
31.00	Primary payer payments	3,066	31.00
32.00	Subtotal (line 30 minus line 31)	5,667,166	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)	684,080	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	444,652	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	541,019	36.00
37.00	Subtotal (see instructions)	6,111,818	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)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,111,818	40.00
40.01	Sequestration adjustment (see instructions)	122,236	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,577,091	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	412,491	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part I Date/Time Prepared: 2/22/2018 11:52 am
	Title XVIII	Hospital	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,263,050		5,500,891	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	03/22/2017	103,100	03/22/2017	76,200	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		103,100		76,200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,366,150		5,577,091	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		412,491	6.01
6.02	SETTLEMENT TO PROGRAM		127,765		0	6.02
7.00	Total Medicare program liability (see instructions)		3,238,385		5,989,582	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		704,105		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)		704,105		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		25,794		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		729,899		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/22/2018 11:52 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1315 Component CCN: 15-Z315	Period: From 10/01/2016 To 09/30/2017	Worksheet E-2 Date/Time Prepared: 2/22/2018 11:52 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	566,976	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)	181,109	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	315	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)	748,085	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	748,085	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)	748,085	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,290	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)	744,795	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	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)	744,795	0	19.00
19.01	Sequestration adjustment (see instructions)	14,896	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	704,105	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)	25,794	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-3 Part V Date/Time Prepared: 2/22/2018 11:52 am

	Title XVIII	Hospital	Cost	
			1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT			
1.00	Inpatient services		3,652,808	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		3,652,808	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,689,336	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
	Customary charges			
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		3,689,336	19.00
20.00	Deductibles (exclude professional component)		409,724	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		3,279,612	22.00
23.00	Coinsurance		329	23.00
24.00	Subtotal (line 22 minus line 23)		3,279,283	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		38,757	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		25,192	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		18,666	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,304,475	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		3,304,475	30.00
30.01	Sequestration adjustment (see instructions)		66,090	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		3,366,150	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)		-127,765	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-3 Part VII Date/Time Prepared: 2/22/2018 11:52 am

		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		74,390		8.00
9.00	Ancillary service charges		160,502	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)		234,892	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)		234,892	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		234,892	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		106,046	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-106,046	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/22/2018 11:52 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	23,340	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	202,744	0	0	0	3.00
4.00	Accounts receivable	10,814,638	0	0	0	4.00
5.00	Other receivable	110,766	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,827,074	0	0	0	7.00
8.00	Prepaid expenses	981,327	0	0	0	8.00
9.00	Other current assets	1,098,890	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,058,779	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,317,868	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	56,786,732	0	0	0	15.00
16.00	Accumulated depreciation	-13,307,611	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	18,884,224	0	0	0	23.00
24.00	Accumulated depreciation	-11,384,058	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	52,297,155	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	21,457,454	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,931,812	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	25,389,266	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	92,745,200	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,920,268	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,769,879	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,022,282	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	776,828	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,489,257	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,133,788	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	44,408,061	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	45,541,849	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	53,031,106	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	39,714,094				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)	39,714,094	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	92,745,200	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/22/2018 11:52 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		40,241,284		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-434,997				2.00
3.00	Total (sum of line 1 and line 2)		39,806,287		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)		39,806,287		0		11.00
12.00	FOUNDATION	92,193		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)		92,193		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39,714,094		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	FOUNDATION		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet G-2 Parts I & II Date/Time Prepared: 2/22/2018 11:52 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,384,139		7,384,139	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,384,139		7,384,139	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	432,414		432,414	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)	432,414		432,414	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,816,553		7,816,553	17.00
18.00	Ancillary services	10,950,684	80,607,866	91,558,550	18.00
19.00	Outpatient services	576,805	16,803,015	17,379,820	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		849,564	849,564	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	324,471	324,471	26.00
27.00	PROFESSIONAL FEES	1,049,574	2,212,758	3,262,332	27.00
27.01	OTHER REVENUE	8,754	4,808,245	4,816,999	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	20,402,370	105,605,919	126,008,289	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		60,198,930		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)		60,198,930		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet G-3 Date/Time Prepared: 2/22/2018 11:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	126,008,289	1.00
2.00	Less contractual allowances and discounts on patients' accounts	69,503,173	2.00
3.00	Net patient revenues (line 1 minus line 2)	56,505,116	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	60,198,930	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,693,814	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,017,695	24.00
24.01	CONTRIBUTIONS	53,235	24.01
24.02	LOSS ON DISPOSAL OF PROPERTY	-105,547	24.02
24.03	CONTRIBUTION TO FOUNDATION	-90,185	24.03
24.04	CHANGE IN ASSETS FOUNDATION	166,706	24.04
24.05	INVESTMENT INCOME	2,192,789	24.05
24.06	OP REVENUE, GROUPED IN OTHER	24,124	24.06
25.00	Total other income (sum of lines 6-24)	3,258,817	25.00
26.00	Total (line 5 plus line 25)	-434,997	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)	-434,997	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

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

Period: From 10/01/2016 To 09/30/2017

Worksheet H

Date/Time Prepared: 2/22/2018 11:52 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	198,572	0	0	15,705	32,063	246,340	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	280,093	0	22,982	0	0	303,075	6.00
7.00	Physical Therapy	153,526	0	0	0	0	153,526	7.00
8.00	Occupational Therapy	28,088	0	0	0	0	28,088	8.00
9.00	Speech Pathology	2,350	0	0	0	0	2,350	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	48,763	0	0	0	0	48,763	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	711,392	0	22,982	15,705	32,063	782,142	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	-113,440	132,900	0	132,900	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	-44,860	258,215	0	258,215	6.00
7.00	Physical Therapy	-1,078	152,448	0	152,448	7.00
8.00	Occupational Therapy	0	28,088	0	28,088	8.00
9.00	Speech Pathology	0	2,350	0	2,350	9.00
10.00	Medical Social Services	19,941	19,941	0	19,941	10.00
11.00	Home Health Aide	-4,065	44,698	0	44,698	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	-143,502	638,640	0	638,640	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part I | Date/Time Prepared: 2/22/2018 11:52 am
HHA CCN: 15-7117

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	132,900	0	0	0	0	132,900	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	258,215	0	0	0	0	258,215	6.00
7.00	Physical Therapy	152,448	0	0	0	0	152,448	7.00
8.00	Occupational Therapy	28,088	0	0	0	0	28,088	8.00
9.00	Speech Pathology	2,350	0	0	0	0	2,350	9.00
10.00	Medical Social Services	19,941	0	0	0	0	19,941	10.00
11.00	Home Health Aide	44,698	0	0	0	0	44,698	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)	638,640	0	0	0	0	638,640	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	132,900		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	67,854	326,069	6.00
7.00	Physical Therapy	40,061	192,509	7.00
8.00	Occupational Therapy	7,381	35,469	8.00
9.00	Speech Pathology	618	2,968	9.00
10.00	Medical Social Services	5,240	25,181	10.00
11.00	Home Health Aide	11,746	56,444	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)		638,640	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part II | Date/Time Prepared: 2/22/2018 11:52 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-132,900	505,740	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	258,215	6.00
7.00	Physical Therapy	0	0	0	0	0	152,448	7.00
8.00	Occupational Therapy	0	0	0	0	0	28,088	8.00
9.00	Speech Pathology	0	0	0	0	0	2,350	9.00
10.00	Medical Social Services	0	0	0	0	0	19,941	10.00
11.00	Home Health Aide	0	0	0	0	0	44,698	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	-132,900	505,740	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		132,900	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.262783	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 2/22/2018 11:52 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	39,768	170,946	210,714	51,171	1.00
2.00	Skilled Nursing Care	326,069	0	0	0	326,069	79,184	2.00
3.00	Physical Therapy	192,509	0	0	0	192,509	46,750	3.00
4.00	Occupational Therapy	35,469	0	0	0	35,469	8,613	4.00
5.00	Speech Pathology	2,968	0	0	0	2,968	721	5.00
6.00	Medical Social Services	25,181	0	0	0	25,181	6,115	6.00
7.00	Home Health Aide	56,444	0	0	0	56,444	13,707	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)	638,640	0	39,768	170,946	849,354	206,261	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	56,577	0	15,837	0	29,105	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	56,577	0	15,837	0	29,105	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

Period: From 10/01/2016 To 09/30/2017

Worksheet H-2 Part I | Date/Time Prepared: 2/22/2018 11:52 am

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	1,623	0	0	365,027	0	365,027	1.00
2.00	Skilled Nursing Care	0	0	0	405,253	0	405,253	2.00
3.00	Physical Therapy	0	0	0	239,259	0	239,259	3.00
4.00	Occupational Therapy	0	0	0	44,082	0	44,082	4.00
5.00	Speech Pathology	0	0	0	3,689	0	3,689	5.00
6.00	Medical Social Services	0	0	0	31,296	0	31,296	6.00
7.00	Home Health Aide	0	0	0	70,151	0	70,151	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,623	0	0	1,158,757	0	1,158,757	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	186,370	591,623	2.00
3.00	Physical Therapy	110,032	349,291	3.00
4.00	Occupational Therapy	20,273	64,355	4.00
5.00	Speech Pathology	1,697	5,386	5.00
6.00	Medical Social Services	14,393	45,689	6.00
7.00	Home Health Aide	32,262	102,413	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)	365,027	1,158,757	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.	0.459888		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period: From 10/01/2016 To 09/30/2017

Worksheet H-2 Part II | Date/Time Prepared: 2/22/2018 11:52 am

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	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	1,469	567,890	0	210,714	1,469	1.00
2.00	Skilled Nursing Care	0	0	0	0	326,069	0	2.00
3.00	Physical Therapy	0	0	0	0	192,509	0	3.00
4.00	Occupational Therapy	0	0	0	0	35,469	0	4.00
5.00	Speech Pathology	0	0	0	0	2,968	0	5.00
6.00	Medical Social Services	0	0	0	0	25,181	0	6.00
7.00	Home Health Aide	0	0	0	0	56,444	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,469	567,890		849,354	1,469	20.00
21.00	Total cost to be allocated	0	39,768	170,946		206,261	56,577	21.00
22.00	Unit cost multiplier	0.000000	27.071477	0.301020		0.242845	38.513955	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	58	0	830	0	5,861	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	58	0	830	0	5,861	20.00
21.00	Total cost to be allocated	0	15,837	0	29,105	0	1,623	21.00
22.00	Unit cost multiplier	0.000000	273.051724	0.000000	35.066265	0.000000	0.276915	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period: From 10/01/2016 To 09/30/2017

Worksheet H-2 Part II

Date/Time Prepared: 2/22/2018 11:52 am

Home Health Agency I | PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 2/22/2018 11:52 am

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	591,623		591,623	1,533	385.92	1.00
2.00	Physical Therapy	3.00	349,291	0	349,291	1,846	189.22	2.00
3.00	Occupational Therapy	4.00	64,355	0	64,355	302	213.10	3.00
4.00	Speech Pathology	5.00	5,386	0	5,386	33	163.21	4.00
5.00	Medical Social Services	6.00	45,689		45,689	33	1,384.52	5.00
6.00	Home Health Aide	7.00	102,413		102,413	1,660	61.69	6.00
7.00	Total (sum of lines 1-6)		1,158,757	0	1,158,757	5,407		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits				
				Part A	Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	321			8.00
9.00	Physical Therapy		99915	0	557			9.00
10.00	Occupational Therapy		99915	0	42			10.00
11.00	Speech Pathology		99915	0	17			11.00
12.00	Medical Social Services		99915	0	8			12.00
13.00	Home Health Aide		99915	0	82			13.00
14.00	Total (sum of lines 8-13)			0	1,027			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			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	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	321		0	123,880		1.00
2.00	Physical Therapy	0	557		0	105,396		2.00
3.00	Occupational Therapy	0	42		0	8,950		3.00
4.00	Speech Pathology	0	17		0	2,775		4.00
5.00	Medical Social Services	0	8		0	11,076		5.00
6.00	Home Health Aide	0	82		0	5,059		6.00
7.00	Total (sum of lines 1-6)	0	1,027		0	257,136		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Program Covered Charges Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		420	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	123,880	1.00
2.00	Physical Therapy	105,396	2.00
3.00	Occupational Therapy	8,950	3.00
4.00	Speech Pathology	2,775	4.00
5.00	Medical Social Services	11,076	5.00
6.00	Home Health Aide	5,059	6.00
7.00	Total (sum of lines 1-6)	257,136	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1315
HHA CCN: 15-7117
Period: From 10/01/2016 To 09/30/2017
Worksheet H-3 Part II
Date/Time Prepared: 2/22/2018 11:52 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.551420	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies	71.00	0.264205	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.404927	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315 HHA CCN: 15-7117	Period: From 10/01/2016 To 09/30/2017	Worksheet H-4 Part I-II Date/Time Prepared: 2/22/2018 11:52 am
	Title XVIII	Home Health Agency I	PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	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	420	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	420	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	420	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	191,040	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	4,768	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,348	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,860	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	802	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	203,818	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	203,818	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	203,818	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	203,818	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	203,818	31.00
31.01	Sequestration adjustment (see instructions)	0	4,076	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	199,742	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 HHA CCN: 15-7117	Period: From 10/01/2016 To 09/30/2017	Worksheet H-5 Date/Time Prepared: 2/22/2018 11:52 am
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		199,742	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		199,742	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		199,742	7.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	10,085	10,085	0	10,085	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	51	51	0	51	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	17,774	17,774	0	17,774	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	11,305	0	11,305	0	11,305	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	70,444	1,825	72,269	0	72,269	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	1,077	0	1,077	0	1,077	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	24,567	0	24,567	0	24,567	33.00
34.00	SPIRITUAL COUNSELING**	5,182	0	5,182	0	5,182	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	4,065	0	4,065	0	4,065	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	116,640	29,735	146,375	0	146,375	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	10,085	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	51	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	17,774	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	11,305	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	72,269	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	1,077	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	24,567	33.00
34.00	SPIRITUAL COUNSELING**	0	5,182	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	4,065	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
	NONREIMBURSABLE COST CENTERS			
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	146,375	100.00

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

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-2 | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	69,757	1,807	71,564	0	71,564	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	1,066	0	1,066	0	1,066	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	24,327	0	24,327	0	24,327	33.00
34.00	SPIRITUAL COUNSELING	5,131	0	5,131	0	5,131	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	4,025	0	4,025	0	4,025	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	104,306	1,807	106,113	0	106,113	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	71,564	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	1,066	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	24,327	33.00
34.00	SPIRITUAL COUNSELING	0	5,131	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	4,025	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	106,113	100.00

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

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-4 | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	687	18	705	0	705	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	11	0	11	0	11	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	240	0	240	0	240	33.00
34.00	SPIRITUAL COUNSELING	51	0	51	0	51	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	40	0	40	0	40	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,029	18	1,047	0	1,047	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	705	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	11	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	240	33.00
34.00	SPIRITUAL COUNSELING	0	51	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	40	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1,047	100.00

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

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-5 | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,149	8,149	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	35,111	35,111	3.00
4.00	ADMINISTRATIVE & GENERAL	10,085	54,082	64,167	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	11,593	11,593	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	51	0	51	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	328	328	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	17,774		17,774	12.00
13.00	VOLUNTEER SERVICE COORDINATION	11,305		11,305	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	106,113		106,113	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,047		1,047	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	146,375	109,263	255,638	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part I | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,149		8,149			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	35,111	0	0	35,111		3.00
4.00	ADMINISTRATIVE & GENERAL	64,167	0	0	0	64,167	4.00
5.00	PLANT OPERATION & MAINTENANCE	11,593	0	0	0	11,593	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	51	0	0	0	51	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	328	0	0	0	328	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	17,774	0	0	0	17,774	12.00
13.00	VOLUNTEER SERVICE COORDINATION	11,305	0	0	0	11,305	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	106,113			34,769	140,882	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,047	0	8,149	342	9,538	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	255,638	0	8,149	35,111	255,638	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part I | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	64,167					4.00
5.00	PLANT OPERATION & MAINTENANCE	3,885	15,478				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	17	0		0	68	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	110	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	5,957	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	3,789	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	47,213					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,196	15,478	0	0	68	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	64,167	15,478	0	0	68	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part I | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	438				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			23,731		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	15,094	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	435	0	23,500	14,947	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	3	0	231	147	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	438	0	23,731	15,094	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part I | Date/Time Prepared: 2/22/2018 11:52 am

Hospice CCN: 15-1561

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		226,977	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	28,661	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	255,638	100.00

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part II | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		301				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	34,091			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-64,167	191,471	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	11,593	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	51	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	328	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	17,774	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	11,305	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			33,759	0	140,882	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	301	332	0	9,538	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	8,149	35,111		64,167	100.00
101.00	UNIT COST MULTIPLIER	0.000000	27.073090	1.029920		0.335126	101.00

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part II | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	301					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	13		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	301	0	0	13	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	15,478	0	0	68	0	100.00
101.00	UNIT COST MULTIPLIER	51.421927	0.000000	0.000000	5.230769	0.000000	101.00

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part II | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,098					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			25,478			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	16,206		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2,085	0	25,230	16,048	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	13	0	248	158	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	438	0	23,731	15,094	0	100.00
101.00	UNIT COST MULTIPLIER	0.208770	0.000000	0.931431	0.931383	0.000000	101.00

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part II | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

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

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-7 | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.551420	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.404927	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.357755	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.264205	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CHEMICAL DEPENDENCY	76.00	3.569942	0	0	0	10.00
10.01	ONCOLOGY	76.01	0.417259	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-8 | Date/Time Prepared: 2/22/2018 11:52 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			226,977	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			2,085	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			108.86	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	1,320	150		9.00
10.00	Program cost (line 8 times line 9)	143,695	16,329		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			0	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			28,661	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			13	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			2,204.69	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			255,638	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			2,098	22.00
23.00	Average cost per diem (line 21 divided by line 22)			121.85	23.00