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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1329	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 2/13/2020 2:38 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/13/2020 Time: 2:38 pm
2. [ ] Manually submitted cost report
3. [1] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [5] 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 MARGARET MARY COMMUNITY HOSPITAL (15-1329) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-276,965	265,217	0	17,110	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	0	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
200.00	Total	0	-276,965	265,217	0	17,110	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: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 321 MITCHELL	PO Box:			1.00
2.00	City: BATESVILLE	State: IN	Zip Code: 47006-	County: RIPLEY	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	MARGARET MARY COMMUNITY HOSPITAL	151329	99915	1	01/07/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	MARGARET MARY COMMUNITY HOSPITAL	157143	99915		03/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	MARGARET MARY COMMUNITY HOSPITAL	151551	99915		12/31/2003				14.00
15.00	Hospital-Based Health Clinic - RHC	MARGARET MARY COMMUNITY HOSPITAL	158511	99915		09/03/2013	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/13/2020 2:38 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/13/2020 2:38 pm

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/13/2020 2:38 pm

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

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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:	469,431	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.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/13/2020 2:38 pm

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		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)	01/01/2018	12/31/2018	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1329	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 2/13/2020 2:38 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 2/13/2020 2:38 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/26/2019	Y	02/26/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 2/13/2020 2:38 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	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.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1329	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 2/13/2020 2:38 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	6,570	105,216.00	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)		18	6,570	105,216.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	5,208.00	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	110,424.00	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: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,631	51	4,384			1.00
2.00	HMO and other (see instructions)	226	431				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,631	51	4,384			7.00
8.00	INTENSIVE CARE UNIT	176	4	217			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	1,049			13.00
14.00	Total (see instructions)	1,807	55	5,650	0.00	607.80	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	5,562	619	10,560	0.00	23.80	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	14.24	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,429	1,308	7,281	0.00	16.29	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	662.13	27.00
28.00	Observation Bed Days		23	829			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	574	13	1,598	1.00
2.00	HMO and other (see instructions)			77	164		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	574	13	1,598	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: 15-1329 | Component CCN: 15-7143 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-4 | Date/Time Prepared: 2/13/2020 2:38 pm

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	241.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			6.37	0.00	6.37	5.00
6.00	Direct Nursing Service			8.15	0.00	8.15	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			4.47	0.00	4.47	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.61	0.00	1.61	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.05	0.00	0.05	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.17	0.00	0.17	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.91	0.00	0.91	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.			2			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
20.01				17140			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,843	709	72	29	2,653	21.00
22.00	Skilled Nursing Visit Charges	309,624	119,112	12,096	4,872	445,704	22.00
23.00	Physical Therapy Visits	1,108	430	24	9	1,571	23.00
24.00	Physical Therapy Visit Charges	223,816	86,860	4,848	1,818	317,342	24.00
25.00	Occupational Therapy Visits	346	298	2	7	653	25.00
26.00	Occupational Therapy Visit Charges	74,520	64,368	432	1,512	140,832	26.00
27.00	Speech Pathology Visits	8	34	0	0	42	27.00
28.00	Speech Pathology Visit Charges	1,308	7,194	0	0	8,502	28.00
29.00	Medical Social Service Visits	0	4	0	0	4	29.00
30.00	Medical Social Service Visit Charges	0	1,280	0	0	1,280	30.00
31.00	Home Health Aide Visits	237	393	2	7	639	31.00
32.00	Home Health Aide Visit Charges	23,463	38,907	198	693	63,261	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,542	1,868	100	52	5,562	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)	632,731	317,721	17,574	8,895	976,921	35.00
36.00	Total Number of Episodes (standard/non outlier)	257		34	1	292	36.00
37.00	Total Number of Outlier Episodes		49		2	51	37.00
38.00	Total Non-Routine Medical Supply Charges	40,485	27,633	1,380	600	70,098	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 2/13/2020 2:38 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			112 N. BUCKEYE ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	OSGOOD		IN	47037	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1329
Component CCN: 15-8511

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-8
Date/Time Prepared:
2/13/2020 2:38 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	06:00	08:00	12:00		11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-1329
Hospice CCN: 15-1551

Period: From 01/01/2018 To 12/31/2018

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	9,441	211	1,603	11,255	11.00
12.00	Hospice Inpatient Respite Care	0	0	4	4	12.00
13.00	Hospice General Inpatient Care	0	0	6	6	13.00
14.00	Total Hospice Days	9,441	211	1,613	11,265	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: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 2/13/2020 2:38 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.383314	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,842,908	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	17,483,441	6.00
7.00	Medicaid cost (line 1 times line 6)	6,701,648	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)	0	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)	0	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)	1,146,253	0	1,146,253	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	439,375	0	439,375	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)	439,375	0	439,375	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)	8,085,181	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	588,029	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	904,661	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,180,520	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,069,026	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,508,401	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,508,401	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		3,247,141	3,247,141	0	3,247,141	1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		832,756	832,756	0	832,756	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		4,928,773	4,928,773	-356,130	4,572,643	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	0	356,130	356,130	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	204,975	12,816,127	13,021,102	-1	13,021,101	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,417,583	9,429,764	15,847,347	434,293	16,281,640	5.00
7.00	00700	OPERATION OF PLANT	0	1,436,222	1,436,222	-241	1,435,981	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	287,365	287,365	0	287,365	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	530,986	16,693	547,679	0	547,679	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	96,884	67,078	163,962	-12,145	151,817	8.00
9.00	00900	HOUSEKEEPING	1,018,349	340,600	1,358,949	-2,140	1,356,809	9.00
10.00	01000	DIETARY	860,570	575,530	1,436,100	-1,277,233	158,867	10.00
11.00	01100	CAFETERIA	0	0	0	1,229,562	1,229,562	11.00
13.00	01300	NURSING ADMINISTRATION	561,423	8,959	570,382	-16	570,366	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	132,765	132,765	-137,776	-5,011	14.00
15.00	01500	PHARMACY	764,443	3,752,534	4,516,977	-32,514	4,484,463	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,484,462	327,060	1,811,522	-71	1,811,451	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,887,879	306,844	3,194,723	487,626	3,682,349	30.00
31.00	03100	INTENSIVE CARE UNIT	304,739	21,686	326,425	-15,145	311,280	31.00
43.00	04300	NURSERY	0	4,255	4,255	700,391	704,646	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,498,820	2,851,821	4,350,641	-2,398,851	1,951,790	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,346,536	299,024	1,645,560	-1,497,077	148,483	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,974,774	7,897,777	10,872,551	-273,062	10,599,489	54.00
60.00	06000	LABORATORY	1,626,035	2,409,898	4,035,933	-160,604	3,875,329	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	568,968	170,456	739,424	-27,120	712,304	65.00
66.00	06600	PHYSICAL THERAPY	1,143,408	61,521	1,204,929	-23,104	1,181,825	66.00
67.00	06700	OCCUPATIONAL THERAPY	373,187	15,029	388,216	-11,623	376,593	67.00
68.00	06800	SPEECH PATHOLOGY	203,397	2,726	206,123	-847	205,276	68.00
69.00	06900	ELECTROCARDIOLOGY	673,842	344,383	1,018,225	-39,062	979,163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,428,834	3,428,834	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,005,152	1,005,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,091,383	97,322	1,188,705	0	1,188,705	88.00
90.00	09000	CLINIC	1,625,969	862,262	2,488,231	-225,876	2,262,355	90.00
90.01	09001	WOUND CLINC	330,219	250,607	580,826	-243,544	337,282	90.01
91.00	09100	EMERGENCY	2,265,827	2,549,576	4,815,403	-179,088	4,636,315	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,753,398	233,842	1,987,240	-66,658	1,920,582	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	778,497	387,628	1,166,125	-14,579	1,151,546	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,386,553	56,966,024	90,352,577	647,481	91,000,058	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,526,041	1,781,597	12,307,638	-143,875	12,163,763	192.00
192.01	19201	PEDIATRICS	655,122	59,137	714,259	-24,681	689,578	192.01
192.02	19202	BROOKVILLE	1,222,324	94,090	1,316,414	-18,014	1,298,400	192.02
192.03	19203	RADIOLOGY - OSGOOD	93,079	0	93,079	0	93,079	192.03
192.04	19204	ENT	232,285	23,157	255,442	-11,014	244,428	192.04
194.00	07950	COMMUNITY RELATIONS	385,183	910,706	1,295,889	-437,071	858,818	194.00
194.01	07951	COMMUNITY BENEFITS	475,570	223,166	698,736	-11,836	686,900	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	47,928	56,208	104,136	-990	103,146	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	71,736	5,139	76,875	0	76,875	194.04
194.05	07955	MMHCB RHC	112,374	4,182	116,556	0	116,556	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	47,208,195	60,123,406	107,331,601	0	107,331,601	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-861,668	2,385,473		1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	832,756		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-149,877	4,422,766		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	356,130		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,021,101		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,251,614	13,030,026		5.00
7.00	00700	OPERATION OF PLANT	-10,916	1,425,065		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	287,365		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	547,679		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	-912	150,905		8.00
9.00	00900	HOUSEKEEPING	0	1,356,809		9.00
10.00	01000	DIETARY	-18,995	139,872		10.00
11.00	01100	CAFETERIA	-364,891	864,671		11.00
13.00	01300	NURSING ADMINISTRATION	0	570,366		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-5,011		14.00
15.00	01500	PHARMACY	-126,564	4,357,899		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,003	1,793,448		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,110,031	2,572,318		30.00
31.00	03100	INTENSIVE CARE UNIT	0	311,280		31.00
43.00	04300	NURSERY	0	704,646		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-75,000	1,876,790		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	148,483		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,163,181	9,436,308		54.00
60.00	06000	LABORATORY	0	3,875,329		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	712,304		65.00
66.00	06600	PHYSICAL THERAPY	-7,499	1,174,326		66.00
67.00	06700	OCCUPATIONAL THERAPY	-525	376,068		67.00
68.00	06800	SPEECH PATHOLOGY	0	205,276		68.00
69.00	06900	ELECTROCARDIOLOGY	-193,810	785,353		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,428,834		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,005,152		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,188,705		88.00
90.00	09000	CLINIC	-979,362	1,282,993		90.00
90.01	09001	WOUND CLINC	0	337,282		90.01
91.00	09100	EMERGENCY	-1,904,837	2,731,478		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,920,582		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	1,151,546		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,237,685	80,762,373		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,163,763		192.00
192.01	19201	PEDIATRICS	0	689,578		192.01
192.02	19202	BROOKVILLE	0	1,298,400		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	93,079		192.03
192.04	19204	ENT	0	244,428		192.04
194.00	07950	COMMUNITY RELATIONS	0	858,818		194.00
194.01	07951	COMMUNITY BENEFITS	0	686,900		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	103,146		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	76,875		194.04
194.05	07955	MMHCB RHC	0	116,556		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,237,685	97,093,916		200.00

RECLASSIFICATIONS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 2/13/2020 2:38 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	763,909	465,653	1.00
	0		763,909	465,653	
	B - OB RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	575,623	67,215	1.00
2.00	NURSERY	43.00	627,158	73,233	2.00
	0		1,202,781	140,448	
	C - COMMUNITY RELATIONS				
1.00	ADMINISTRATIVE & GENERAL	5.00	134,814	301,681	1.00
	0		134,814	301,681	
	D - OFFSITE BUILDING DEPR RECLASS				
1.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	356,130	1.00
2.00		0.00	0	0	2.00
	0		0	356,130	
	E - IMPLANTABLE SUPPLIES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,005,152	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	0		0	1,005,152	
	G - CENTRAL SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,438,941	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
	0		0	3,438,941	
500.00	Grand Total: Increases		2,101,504	5,708,005	500.00

RECLASSIFICATIONS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 2/13/2020 2:38 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	763,909	465,653	0	1.00
	0		763,909	465,653		
	B - OB RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,202,781	140,448	0	1.00
2.00		0.00	0	0	0	2.00
	0		1,202,781	140,448		
	C - COMMUNITY RELATIONS					
1.00	COMMUNITY RELATIONS	194.00	134,814	301,681	0	1.00
	0		134,814	301,681		
	D - OFFSITE BUILDING DEPR RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	356,130	9	1.00
2.00		0.00	0	0	9	2.00
	0		0	356,130		
	E - IMPLANTABLE SUPPLIES RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	23,246	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,011	0	2.00
3.00	OPERATING ROOM	50.00	0	935,413	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	15,161	0	4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,107	0	5.00
6.00	CLINIC	90.00	0	2,527	0	6.00
7.00	WOUND CLINC	90.01	0	17,182	0	7.00
8.00	EMERGENCY	91.00	0	505	0	8.00
	0		0	1,005,152		
	G - CENTRAL SUPPLY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,202	0	2.00
3.00	OPERATION OF PLANT	7.00	0	241	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	12,145	0	4.00
5.00	HOUSEKEEPING	9.00	0	2,140	0	5.00
6.00	DIETARY	10.00	0	47,671	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	16	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	137,776	0	8.00
9.00	PHARMACY	15.00	0	32,514	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	71	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	131,966	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	14,134	0	12.00
13.00	OPERATING ROOM	50.00	0	1,463,438	0	13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	138,687	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	273,062	0	15.00
16.00	LABORATORY	60.00	0	160,604	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	27,120	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	23,104	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	11,623	0	19.00
20.00	SPEECH PATHOLOGY	68.00	0	847	0	20.00
21.00	ELECTROCARDIOLOGY	69.00	0	39,062	0	21.00
22.00	CLINIC	90.00	0	223,349	0	22.00
23.00	WOUND CLINC	90.01	0	226,362	0	23.00
24.00	EMERGENCY	91.00	0	178,583	0	24.00
25.00	HOME HEALTH AGENCY	101.00	0	66,658	0	25.00
26.00	HOSPICE	116.00	0	14,579	0	26.00
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	143,875	0	27.00
28.00	PEDIATRICS	192.01	0	24,681	0	28.00
29.00	BROOKVILLE	192.02	0	18,014	0	29.00
30.00	ENT	192.04	0	11,014	0	30.00
31.00	COMMUNITY RELATIONS	194.00	0	576	0	31.00
32.00	COMMUNITY BENEFITS	194.01	0	11,836	0	32.00
33.00	EMS	194.03	0	990	0	33.00
	0		0	3,438,941		
500.00	Grand Total: Decreases		2,101,504	5,708,005		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,553,658	0	0	0	0	1.00
2.00	Land Improvements	557,745	0	0	0	285,701	2.00
3.00	Buildings and Fixtures	80,587,989	2,245,692	0	2,245,692	2,937,416	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6,340,280	0	0	0	1,094,512	5.00
6.00	Movable Equipment	58,892,305	16,365,009	0	16,365,009	17,929,882	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	148,931,977	18,610,701	0	18,610,701	22,247,511	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	148,931,977	18,610,701	0	18,610,701	22,247,511	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,553,658	0	1.00
2.00	Land Improvements	272,044	0	2.00
3.00	Buildings and Fixtures	79,896,265	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	5,245,768	0	5.00
6.00	Movable Equipment	57,327,432	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	145,295,167	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	145,295,167	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 2/13/2020 2:38 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,222,174	0	1,024,967	0	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	832,756	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,928,773	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	7,983,703	0	1,024,967	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,247,141	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	832,756	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,928,773	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	2.01
3.00	Total (sum of lines 1-2)	0	9,008,670	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 2/13/2020 2:38 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	60,623,612	0	60,623,612	0.417245	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	20,177,119	0	20,177,119	0.138870	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	64,494,436	0	64,494,436	0.443885	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	145,295,167	0	145,295,167	0.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,222,174	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	832,756	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,422,766	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	356,130	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	7,833,826	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	163,299	0	0	0	2,385,473	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0	832,756	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,422,766	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	356,130	2.01
3.00	Total (sum of lines 1-2)	163,299	0	0	0	7,997,125	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 2/13/2020 2:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,009,174			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-OFFSITE BLDG		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	26.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 2/13/2020 2:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-149,877	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHEROPERATING GIRLS ON THE RUN REVE	B	-37,005	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHEROPERATING OTHOP - INTERNAL SALE	B	3,967	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MMCH OTHER OPERATING COMMBENEFITS SC	B	-5,651	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHEROPERATING DIABETES PROGRAM	B	-10,174	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHEROPERATING OTHOP-COMMUNITY CLASS	B	-5,942	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHEROPERATING OTHOP - MISC REVENUE	B	-10,916	OPERATION OF PLANT	7.00	0	38.00
40.00	OTHEROPERATING OTHOP - LAUNDRY SERVI	B	-912	LAUNDRY & LINEN SERVICE	8.00	0	40.00
41.00	OTHEROPERATING OTHOP - VENDING SALES	B	-3,956	DIETARY	10.00	0	41.00
43.00	OTHEROPERATING OTHOP - DIET SUPP/INS	B	-6,347	DIETARY	10.00	0	43.00
44.00	CAFETERIA OFFSET	B	-364,891	CAFETERIA	11.00	0	44.00
45.00	OTHEROPERATING OTHOP - MEDRED TRANSC	B	-18,003	MEDICAL RECORDS & LIBRARY	16.00	0	45.00
45.01	OTHEROPERATING OTHOP-PHYSICAL THERAP	B	-7,499	PHYSICAL THERAPY	66.00	0	45.01
45.02	OTHEROPERATING OTHOP-OCCUPATIONAL T	B	-525	OCCUPATIONAL THERAPY	67.00	0	45.02
45.03	INTEREST OFFSET	A	-861,668	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.03
45.04	LOBBYING EXPENSE	A	-5,682	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	MEDICAL STAFF RETENTION COST	A	-63,723	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	MEDICAL STAFF PLACEMENT FEE	A	-82,085	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	PHYSICIAN RECRUITMENT	A	-66,832	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	HAF	A	-2,975,756	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	TELEPHONE & TV OFFSET	A	-2,731	ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10	BOUTIQUE OFFSET	A	-744	RADIOLOGY-DIAGNOSTIC	54.00	0	45.10
45.11	HOSPITALIST OFFSET	A	-416,303	ADULTS & PEDIATRICS	30.00	0	45.11
45.12	340B EXPENSE	A	-126,564	PHARMACY	15.00	0	45.12
45.13	DIETARY REVENUE	B	-8,692	DIETARY	10.00	0	45.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,237,685				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 2/13/2020 2:38 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	4,796	0	4,796	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	778,728	693,728	85,000	0	0	2.00
3.00	50.00	OPERATING ROOM	130,000	75,000	55,000	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,220,437	1,162,437	58,000	0	0	4.00
5.00	60.00	LABORATORY	71,094	0	71,094	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	205,810	193,810	12,000	0	0	6.00
7.00	90.00	CLINIC	979,362	979,362	0	0	0	7.00
8.00	91.00	EMERGENCY	2,315,904	1,904,837	411,067	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			5,706,131	5,009,174	696,957		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	5.00	ADMINISTRATIVE & GENERAL	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	693,728		2.00
3.00	50.00	OPERATING ROOM	0	0	0	75,000		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,162,437		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	193,810		6.00
7.00	90.00	CLINIC	0	0	0	979,362		7.00
8.00	91.00	EMERGENCY	0	0	0	1,904,837		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	5,009,174		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,385,473	2,385,473				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	832,756	0	832,756			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,422,766			4,422,766		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	356,130			0	356,130	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,021,101	10,016	0	18,570	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,030,026	365,729	0	678,077	0	5.00
7.00	00700	OPERATION OF PLANT	1,425,065	395,778	0	733,787	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	287,365	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	547,679	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	150,905	26,585	0	49,290	0	8.00
9.00	00900	HOUSEKEEPING	1,356,809	30,313	0	56,202	0	9.00
10.00	01000	DIETARY	139,872	10,282	0	19,063	0	10.00
11.00	01100	CAFETERIA	864,671	79,519	0	147,432	0	11.00
13.00	01300	NURSING ADMINISTRATION	570,366	902	0	1,673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-5,011	11,199	0	20,764	0	14.00
15.00	01500	PHARMACY	4,357,899	12,472	0	23,123	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,793,448	43,125	0	79,956	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,572,318	211,233	0	391,634	0	30.00
31.00	03100	INTENSIVE CARE UNIT	311,280	20,549	0	38,099	0	31.00
43.00	04300	NURSERY	704,646	10,903	0	20,215	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,876,790	69,829	0	129,466	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	148,483	17,502	0	32,449	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,436,308	283,059	0	524,803	0	54.00
60.00	06000	LABORATORY	3,875,329	51,484	0	95,454	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	712,304	39,368	0	72,989	0	65.00
66.00	06600	PHYSICAL THERAPY	1,174,326	82,434	0	152,835	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	376,068	17,295	0	32,065	0	67.00
68.00	06800	SPEECH PATHOLOGY	205,276	15,800	0	29,294	0	68.00
69.00	06900	ELECTROCARDIOLOGY	785,353	35,654	0	66,104	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,428,834	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,005,152	43,495	0	80,642	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,188,705	0	54,326	0	23,232	88.00
90.00	09000	CLINIC	1,282,993	207,386	22,563	384,502	9,649	90.00
90.01	09001	WOUND CLINC	337,282	9,986	0	18,515	0	90.01
91.00	09100	EMERGENCY	2,731,478	135,634	0	251,471	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,920,582	50,522	2,345	93,671	1,003	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,151,546	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,762,373	2,288,053	79,234	4,242,145	33,884	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,163,763	47,445	603,910	87,965	258,264	192.00
192.01	19201	PEDIATRICS	689,578	27,650	0	51,265	0	192.01
192.02	19202	BROOKVILLE	1,298,400	0	143,626	0	61,422	192.02
192.03	19203	RADIOLOGY - OSGOOD	93,079	0	3,405	0	1,456	192.03
192.04	19204	ENT	244,428	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	858,818	4,483	0	8,311	0	194.00
194.01	07951	COMMUNITY BENEFITS	686,900	17,842	0	33,080	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	103,146	0	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	76,875	0	0	0	0	194.04
194.05	07955	MMHCB RHC	116,556	0	2,581	0	1,104	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	97,093,916	2,385,473	832,756	4,422,766	356,130	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,049,687					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,819,168	15,893,000	15,893,000			5.00
7.00	00700	OPERATION OF PLANT	0	2,554,630	500,002	3,054,632		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	287,365	56,244	0	343,609	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	147,420	695,099	136,048	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	26,898	253,678	49,651	50,316	0	8.00
9.00	00900	HOUSEKEEPING	282,728	1,726,052	337,830	57,373	0	9.00
10.00	01000	DIETARY	26,836	196,053	38,372	19,460	0	10.00
11.00	01100	CAFETERIA	212,087	1,303,709	255,167	150,501	0	11.00
13.00	01300	NURSING ADMINISTRATION	155,870	728,811	142,646	1,708	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,952	5,275	21,196	0	14.00
15.00	01500	PHARMACY	212,235	4,605,729	901,452	23,604	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	412,137	2,328,666	455,776	81,621	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	961,586	4,136,771	809,665	399,788	0	30.00
31.00	03100	INTENSIVE CARE UNIT	84,606	454,534	88,963	38,892	0	31.00
43.00	04300	NURSERY	174,120	909,884	178,086	20,636	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	416,123	2,492,208	487,785	132,161	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,911	238,345	46,650	33,124	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	825,898	11,070,068	2,166,678	535,731	0	54.00
60.00	06000	LABORATORY	451,443	4,473,710	875,612	97,441	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	157,965	982,626	192,323	74,509	0	65.00
66.00	06600	PHYSICAL THERAPY	317,449	1,727,044	338,024	156,017	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	103,609	529,037	103,545	32,732	0	67.00
68.00	06800	SPEECH PATHOLOGY	56,470	306,840	60,056	29,904	0	68.00
69.00	06900	ELECTROCARDIOLOGY	187,081	1,074,192	210,245	67,481	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,428,834	671,105	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,129,289	221,029	82,321	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	303,005	1,569,268	307,143	0	22,416	88.00
90.00	09000	CLINIC	451,424	2,358,517	461,618	392,508	9,310	90.00
90.01	09001	WOUND CLINC	91,680	457,463	89,536	18,900	0	90.01
91.00	09100	EMERGENCY	629,071	3,747,654	733,506	256,706	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	486,803	2,554,926	500,060	95,621	968	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	216,137	1,367,683	267,688	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,249,760	75,608,637	11,687,780	2,870,251	32,694	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,922,386	16,083,733	3,148,008	89,797	249,183	192.00
192.01	19201	PEDIATRICS	181,884	950,377	186,012	52,332	0	192.01
192.02	19202	BROOKVILLE	339,359	1,842,807	360,682	0	59,262	192.02
192.03	19203	RADIOLOGY - OSGOOD	25,842	123,782	24,227	0	1,405	192.03
192.04	19204	ENT	64,490	308,918	60,463	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	69,511	941,123	184,200	8,484	0	194.00
194.01	07951	COMMUNITY BENEFITS	132,034	869,856	170,252	33,768	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	13,306	116,452	22,792	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	19,916	96,791	18,944	0	0	194.04
194.05	07955	MMHCB RHC	31,199	151,440	29,640	0	1,065	194.05
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,049,687	97,093,916	15,893,000	3,054,632	343,609	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	831,147					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	8,909	362,554				8.00
9.00	00900	HOUSEKEEPING	10,158	84,905	2,216,318			9.00
10.00	01000	DIETARY	3,446	304	13,202	270,837		10.00
11.00	01100	CAFETERIA	26,648	2,351	102,103	0	1,840,479	11.00
13.00	01300	NURSING ADMINISTRATION	302	0	1,159	0	45,290	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,753	3,649	14,380	0	0	14.00
15.00	01500	PHARMACY	4,179	0	16,013	0	53,299	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,452	0	55,373	0	141,184	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,786	58,003	271,222	256,356	322,040	30.00
31.00	03100	INTENSIVE CARE UNIT	6,886	2,388	26,385	14,481	31,965	31.00
43.00	04300	NURSERY	3,654	16,757	14,000	0	64,977	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,400	28,767	89,660	0	167,459	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,865	2,372	22,472	0	11,678	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,856	43,935	363,446	0	150,691	54.00
60.00	06000	LABORATORY	17,253	0	66,105	0	208,108	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	13,192	4,175	50,548	0	54,198	65.00
66.00	06600	PHYSICAL THERAPY	27,624	30,226	105,845	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,796	0	22,206	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,295	0	20,288	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,948	3,326	45,780	0	69,694	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,576	17,603	55,848	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	79,943	25,391	266,283	0	0	90.00
90.01	09001	WOUND CLINC	3,346	4,421	12,822	0	0	90.01
91.00	09100	EMERGENCY	45,452	22,875	174,154	0	237,153	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	18,016	0	69,031	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	519,735	351,448	1,878,325	270,837	1,557,736	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	226,977	11,106	273,825	0	162,968	192.00
192.01	19201	PEDIATRICS	9,266	0	35,503	0	41,921	192.01
192.02	19202	BROOKVILLE	66,493	0	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	1,502	0	5,756	0	22,383	194.00
194.01	07951	COMMUNITY BENEFITS	5,979	0	22,909	0	48,359	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	7,112	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	1,195	0	0	0	0	194.05
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)	831,147	362,554	2,216,318	270,837	1,840,479	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	919,916					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	75,205				14.00
15.00	01500	PHARMACY	41,258	0	5,645,534			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,077,072		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	249,283	0	0	2,024,389	8,598,303	30.00
31.00	03100	INTENSIVE CARE UNIT	24,755	0	0	0	689,249	31.00
43.00	04300	NURSERY	50,303	0	0	0	1,258,297	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	226,732	3,648,172	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,045	0	0	0	369,551	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	116,669	0	0	412,975	14,955,049	54.00
60.00	06000	LABORATORY	161,086	0	0	0	5,899,315	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	41,968	0	0	0	1,413,539	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,384,780	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	693,316	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	422,383	68.00
69.00	06900	ELECTROCARDIOLOGY	36,477	0	0	24,293	1,543,436	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,205	0	0	4,175,144	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,520,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,645,534	0	5,645,534	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,898,827	88.00
90.00	09000	CLINIC	0	0	0	113,366	3,706,936	90.00
90.01	09001	WOUND CLINC	0	0	0	0	586,488	90.01
91.00	09100	EMERGENCY	183,573	0	0	251,024	5,652,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	3,238,622	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	1,635,371	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	914,417	75,205	5,645,534	3,052,779	69,935,075	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	24,293	20,269,890	192.00
192.01	19201	PEDIATRICS	0	0	0	0	1,275,411	192.01
192.02	19202	BROOKVILLE	0	0	0	0	2,329,244	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	149,414	192.03
192.04	19204	ENT	0	0	0	0	369,381	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	1,163,448	194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0	0	1,151,123	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	5,499	0	0	0	151,855	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	115,735	194.04
194.05	07955	MMHCB RHC	0	0	0	0	183,340	194.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	919,916	75,205	5,645,534	3,077,072	97,093,916	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
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	0	8,598,303		30.00
31.00	03100	INTENSIVE CARE UNIT	0	689,249		31.00
43.00	04300	NURSERY	0	1,258,297		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,648,172		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	369,551		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,955,049		54.00
60.00	06000	LABORATORY	0	5,899,315		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	1,413,539		65.00
66.00	06600	PHYSICAL THERAPY	0	2,384,780		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	693,316		67.00
68.00	06800	SPEECH PATHOLOGY	0	422,383		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,543,436		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,175,144		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,520,666		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,645,534		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,898,827		88.00
90.00	09000	CLINIC	0	3,706,936		90.00
90.01	09001	WOUND CLINC	0	586,488		90.01
91.00	09100	EMERGENCY	0	5,652,097		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	3,238,622		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	1,635,371		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	69,935,075		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,269,890		192.00
192.01	19201	PEDIATRICS	0	1,275,411		192.01
192.02	19202	BROOKVILLE	0	2,329,244		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	149,414		192.03
192.04	19204	ENT	0	369,381		192.04
194.00	07950	COMMUNITY RELATIONS	0	1,163,448		194.00
194.01	07951	COMMUNITY BENEFITS	0	1,151,123		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	151,855		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	115,735		194.04
194.05	07955	MMHCB RHC	0	183,340		194.05
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	97,093,916		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,016	0	18,570	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	365,729	0	678,077	0	5.00
7.00	00700	OPERATION OF PLANT	0	395,778	0	733,787	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,585	0	49,290	0	8.00
9.00	00900	HOUSEKEEPING	0	30,313	0	56,202	0	9.00
10.00	01000	DIETARY	0	10,282	0	19,063	0	10.00
11.00	01100	CAFETERIA	0	79,519	0	147,432	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	902	0	1,673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,199	0	20,764	0	14.00
15.00	01500	PHARMACY	0	12,472	0	23,123	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	43,125	0	79,956	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	211,233	0	391,634	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	20,549	0	38,099	0	31.00
43.00	04300	NURSERY	0	10,903	0	20,215	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	69,829	0	129,466	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,502	0	32,449	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	283,059	0	524,803	0	54.00
60.00	06000	LABORATORY	0	51,484	0	95,454	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	39,368	0	72,989	0	65.00
66.00	06600	PHYSICAL THERAPY	0	82,434	0	152,835	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17,295	0	32,065	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,800	0	29,294	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	35,654	0	66,104	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	43,495	0	80,642	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	54,326	0	23,232	88.00
90.00	09000	CLINIC	0	207,386	22,563	384,502	9,649	90.00
90.01	09001	WOUND CLINC	0	9,986	0	18,515	0	90.01
91.00	09100	EMERGENCY	0	135,634	0	251,471	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	50,522	2,345	93,671	1,003	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,288,053	79,234	4,242,145	33,884	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	47,445	603,910	87,965	258,264	192.00
192.01	19201	PEDIATRICS	0	27,650	0	51,265	0	192.01
192.02	19202	BROOKVILLE	0	0	143,626	0	61,422	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	3,405	0	1,456	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	4,483	0	8,311	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	17,842	0	33,080	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	2,581	0	1,104	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,385,473	832,756	4,422,766	356,130	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	28,586	28,586				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,043,806	3,984	1,047,790			5.00
7.00	00700	OPERATION OF PLANT	1,129,565	0	32,965	1,162,530		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	3,708	0	3,708	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	323	8,970	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	75,875	59	3,273	19,149	0	8.00
9.00	00900	HOUSEKEEPING	86,515	619	22,273	21,835	0	9.00
10.00	01000	DIETARY	29,345	59	2,530	7,406	0	10.00
11.00	01100	CAFETERIA	226,951	464	16,823	57,278	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,575	341	9,405	650	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,963	0	348	8,067	0	14.00
15.00	01500	PHARMACY	35,595	465	59,432	8,983	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	123,081	903	30,049	31,063	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	602,867	2,106	53,381	152,151	0	30.00
31.00	03100	INTENSIVE CARE UNIT	58,648	185	5,865	14,802	0	31.00
43.00	04300	NURSERY	31,118	381	11,741	7,854	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	199,295	911	32,159	50,298	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,951	87	3,076	12,606	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	807,862	1,809	142,848	203,887	0	54.00
60.00	06000	LABORATORY	146,938	989	57,729	37,084	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	112,357	346	12,680	28,356	0	65.00
66.00	06600	PHYSICAL THERAPY	235,269	695	22,286	59,377	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,360	227	6,827	12,457	0	67.00
68.00	06800	SPEECH PATHOLOGY	45,094	124	3,959	11,381	0	68.00
69.00	06900	ELECTROCARDIOLOGY	101,758	410	13,861	25,682	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	44,246	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	124,137	0	14,572	31,330	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	77,558	664	20,250	0	242	88.00
90.00	09000	CLINIC	624,100	989	30,434	149,380	100	90.00
90.01	09001	WOUND CLINC	28,501	201	5,903	7,193	0	90.01
91.00	09100	EMERGENCY	387,105	1,378	48,360	97,697	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	147,541	1,066	32,969	36,391	10	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	473	17,649	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,643,316	20,258	770,571	1,092,357	352	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	997,584	6,407	207,517	34,175	2,690	192.00
192.01	19201	PEDIATRICS	78,915	398	12,264	19,917	0	192.01
192.02	19202	BROOKVILLE	205,048	743	23,780	0	640	192.02
192.03	19203	RADIOLOGY - OSGOOD	4,861	57	1,597	0	15	192.03
192.04	19204	ENT	0	141	3,986	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	12,794	152	12,144	3,229	0	194.00
194.01	07951	COMMUNITY BENEFITS	50,922	289	11,225	12,852	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	29	1,503	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	44	1,249	0	0	194.04
194.05	07955	MMHCB RHC	3,685	68	1,954	0	11	194.05
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,997,125	28,586	1,047,790	1,162,530	3,708	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	9,293					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	100	98,456				8.00
9.00	00900	HOUSEKEEPING	114	23,060	154,416			9.00
10.00	01000	DIETARY	39	82	920	40,381		10.00
11.00	01100	CAFETERIA	298	638	7,114	0	309,566	11.00
13.00	01300	NURSING ADMINISTRATION	3	0	81	0	7,618	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	42	991	1,002	0	0	14.00
15.00	01500	PHARMACY	47	0	1,116	0	8,965	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	162	0	3,858	0	23,747	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	791	15,751	18,897	38,222	54,168	30.00
31.00	03100	INTENSIVE CARE UNIT	77	648	1,838	2,159	5,376	31.00
43.00	04300	NURSERY	41	4,550	975	0	10,929	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	262	7,812	6,247	0	28,166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66	644	1,566	0	1,964	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,061	11,931	25,320	0	25,346	54.00
60.00	06000	LABORATORY	193	0	4,606	0	35,003	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	148	1,134	3,522	0	9,116	65.00
66.00	06600	PHYSICAL THERAPY	309	8,208	7,374	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	65	0	1,547	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	59	0	1,413	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	134	903	3,190	0	11,722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	163	4,780	3,891	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	894	6,895	18,553	0	0	90.00
90.01	09001	WOUND CLINC	37	1,201	893	0	0	90.01
91.00	09100	EMERGENCY	508	6,212	12,134	0	39,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	201	0	4,810	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,814	95,440	130,867	40,381	262,009	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,535	3,016	19,078	0	27,411	192.00
192.01	19201	PEDIATRICS	104	0	2,474	0	7,051	192.01
192.02	19202	BROOKVILLE	743	0	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	17	0	401	0	3,765	194.00
194.01	07951	COMMUNITY BENEFITS	67	0	1,596	0	8,134	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	1,196	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	13	0	0	0	0	194.05
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)	9,293	98,456	154,416	40,381	309,566	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	20,673					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,764				14.00
15.00	01500	PHARMACY	927	0	115,530			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	212,863		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,603	0	0	140,043	1,083,980	30.00
31.00	03100	INTENSIVE CARE UNIT	556	0	0	0	90,154	31.00
43.00	04300	NURSERY	1,130	0	0	0	68,719	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	15,685	340,835	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	203	0	0	0	70,163	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,622	0	0	28,568	1,251,254	54.00
60.00	06000	LABORATORY	3,620	0	0	0	286,162	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	943	0	0	0	168,602	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	333,518	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	70,483	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	62,030	68.00
69.00	06900	ELECTROCARDIOLOGY	820	0	0	1,680	160,160	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,764	0	0	84,010	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	178,873	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	115,530	0	115,530	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	98,714	88.00
90.00	09000	CLINIC	0	0	0	7,842	839,187	90.00
90.01	09001	WOUND CLINC	0	0	0	0	43,929	90.01
91.00	09100	EMERGENCY	4,125	0	0	17,365	614,773	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	222,988	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	18,122	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,549	39,764	115,530	211,183	6,202,186	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,680	1,302,093	192.00
192.01	19201	PEDIATRICS	0	0	0	0	121,123	192.01
192.02	19202	BROOKVILLE	0	0	0	0	230,954	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	6,530	192.03
192.04	19204	ENT	0	0	0	0	4,127	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	32,502	194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0	0	85,085	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	124	0	0	0	2,852	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	1,293	194.04
194.05	07955	MMHCB RHC	0	0	0	0	5,731	194.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	2,649	0	0	2,649	201.00
202.00		TOTAL (sum lines 118 through 201)	20,673	42,413	115,530	212,863	7,997,125	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
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	0	1,083,980		30.00
31.00	03100	INTENSIVE CARE UNIT	0	90,154		31.00
43.00	04300	NURSERY	0	68,719		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	340,835		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	70,163		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,251,254		54.00
60.00	06000	LABORATORY	0	286,162		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	168,602		65.00
66.00	06600	PHYSICAL THERAPY	0	333,518		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	70,483		67.00
68.00	06800	SPEECH PATHOLOGY	0	62,030		68.00
69.00	06900	ELECTROCARDIOLOGY	0	160,160		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84,010		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	178,873		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	115,530		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	98,714		88.00
90.00	09000	CLINIC	0	839,187		90.00
90.01	09001	WOUND CLINC	0	43,929		90.01
91.00	09100	EMERGENCY	0	614,773		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	222,988		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	18,122		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,202,186		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,302,093		192.00
192.01	19201	PEDIATRICS	0	121,123		192.01
192.02	19202	BROOKVILLE	0	230,954		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	6,530		192.03
192.04	19204	ENT	0	4,127		192.04
194.00	07950	COMMUNITY RELATIONS	0	32,502		194.00
194.01	07951	COMMUNITY BENEFITS	0	85,085		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	2,852		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	1,293		194.04
194.05	07955	MMHCB RHC	0	5,731		194.05
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	2,649		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,997,125		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	161,243					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	77,764				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			161,243			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			0	77,764		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	677	0	677	0	47,003,220	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,721	0	24,721	0	6,552,397	5.00
7.00	00700	OPERATION OF PLANT	26,752	0	26,752	0	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	530,986	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,797	0	1,797	0	96,884	8.00
9.00	00900	HOUSEKEEPING	2,049	0	2,049	0	1,018,349	9.00
10.00	01000	DIETARY	695	0	695	0	96,661	10.00
11.00	01100	CAFETERIA	5,375	0	5,375	0	763,909	11.00
13.00	01300	NURSING ADMINISTRATION	61	0	61	0	561,423	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	757	0	757	0	0	14.00
15.00	01500	PHARMACY	843	0	843	0	764,443	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,915	0	2,915	0	1,484,462	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,278	0	14,278	0	3,463,502	30.00
31.00	03100	INTENSIVE CARE UNIT	1,389	0	1,389	0	304,739	31.00
43.00	04300	NURSERY	737	0	737	0	627,158	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,720	0	4,720	0	1,498,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,183	0	1,183	0	143,755	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,133	0	19,133	0	2,974,774	54.00
60.00	06000	LABORATORY	3,480	0	3,480	0	1,626,035	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,661	0	2,661	0	568,968	65.00
66.00	06600	PHYSICAL THERAPY	5,572	0	5,572	0	1,143,408	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,169	0	1,169	0	373,187	67.00
68.00	06800	SPEECH PATHOLOGY	1,068	0	1,068	0	203,397	68.00
69.00	06900	ELECTROCARDIOLOGY	2,410	0	2,410	0	673,842	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,940	0	2,940	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,073	0	5,073	1,091,383	88.00
90.00	09000	CLINIC	14,018	2,107	14,018	2,107	1,625,969	90.00
90.01	09001	WOUND CLINC	675	0	675	0	330,219	90.01
91.00	09100	EMERGENCY	9,168	0	9,168	0	2,265,827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,415	219	3,415	219	1,753,398	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	778,497	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	154,658	7,399	154,658	7,399	33,316,392	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,207	56,394	3,207	56,394	10,526,041	192.00
192.01	19201	PEDIATRICS	1,869	0	1,869	0	655,122	192.01
192.02	19202	BROOKVILLE	0	13,412	0	13,412	1,222,324	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	318	0	318	93,079	192.03
192.04	19204	ENT	0	0	0	0	232,285	192.04
194.00	07950	COMMUNITY RELATIONS	303	0	303	0	250,369	194.00
194.01	07951	COMMUNITY BENEFITS	1,206	0	1,206	0	475,570	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	47,928	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	71,736	194.04
194.05	07955	MMHCB RHC	0	241	0	241	112,374	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,385,473	832,756	4,422,766	356,130	13,049,687	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.794273	10.708760	27.429197	4.579626	0.277634	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					28,586	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000608	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-15,893,000	81,200,916				5.00
7.00	00700	OPERATION OF PLANT	0	2,554,630	109,093			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	287,365	0	77,764		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	695,099	0	0	167,648	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	253,678	1,797	0	1,797	8.00
9.00	00900	HOUSEKEEPING	0	1,726,052	2,049	0	2,049	9.00
10.00	01000	DIETARY	0	196,053	695	0	695	10.00
11.00	01100	CAFETERIA	0	1,303,709	5,375	0	5,375	11.00
13.00	01300	NURSING ADMINISTRATION	0	728,811	61	0	61	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,952	757	0	757	14.00
15.00	01500	PHARMACY	0	4,605,729	843	0	843	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,328,666	2,915	0	2,915	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,136,771	14,278	0	14,278	30.00
31.00	03100	INTENSIVE CARE UNIT	0	454,534	1,389	0	1,389	31.00
43.00	04300	NURSERY	0	909,884	737	0	737	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,492,208	4,720	0	4,720	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	238,345	1,183	0	1,183	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,070,068	19,133	0	19,133	54.00
60.00	06000	LABORATORY	0	4,473,710	3,480	0	3,480	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	982,626	2,661	0	2,661	65.00
66.00	06600	PHYSICAL THERAPY	0	1,727,044	5,572	0	5,572	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	529,037	1,169	0	1,169	67.00
68.00	06800	SPEECH PATHOLOGY	0	306,840	1,068	0	1,068	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,074,192	2,410	0	2,410	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,428,834	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,129,289	2,940	0	2,940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,569,268	0	5,073	0	88.00
90.00	09000	CLINIC	0	2,358,517	14,018	2,107	16,125	90.00
90.01	09001	WOUND CLINC	0	457,463	675	0	675	90.01
91.00	09100	EMERGENCY	0	3,747,654	9,168	0	9,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,554,926	3,415	219	3,634	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,367,683	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,893,000	59,715,637	102,508	7,399	104,834	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,083,733	3,207	56,394	45,783	192.00
192.01	19201	PEDIATRICS	0	950,377	1,869	0	1,869	192.01
192.02	19202	BROOKVILLE	0	1,842,807	0	13,412	13,412	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	123,782	0	318	0	192.03
192.04	19204	ENT	0	308,918	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	941,123	303	0	303	194.00
194.01	07951	COMMUNITY BENEFITS	0	869,856	1,206	0	1,206	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	116,452	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	96,791	0	0	0	194.04
194.05	07955	MMHCB RHC	0	151,440	0	241	241	194.05
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)		15,893,000	3,054,632	343,609	831,147	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.195724	28.000257	4.418613	4.957691	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,047,790	1,162,530	3,708	9,293	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.012904	10.656321	0.047683	0.055432	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	370,310					8.00
9.00	00900	HOUSEKEEPING	86,722	116,674				9.00
10.00	01000	DIETARY	310	695	14,532			10.00
11.00	01100	CAFETERIA	2,401	5,375	0	24,586		11.00
13.00	01300	NURSING ADMINISTRATION	0	61	0	605	330,217	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,727	757	0	0	0	14.00
15.00	01500	PHARMACY	0	843	0	712	14,810	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,915	0	1,886	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,244	14,278	13,755	4,302	89,484	30.00
31.00	03100	INTENSIVE CARE UNIT	2,439	1,389	777	427	8,886	31.00
43.00	04300	NURSERY	17,115	737	0	868	18,057	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,382	4,720	0	2,237	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,423	1,183	0	156	3,247	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,875	19,133	0	2,013	41,880	54.00
60.00	06000	LABORATORY	0	3,480	0	2,780	57,824	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,264	2,661	0	724	15,065	65.00
66.00	06600	PHYSICAL THERAPY	30,873	5,572	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,169	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,068	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,397	2,410	0	931	13,094	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,980	2,940	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	25,934	14,018	0	0	0	90.00
90.01	09001	WOUND CLINC	4,516	675	0	0	0	90.01
91.00	09100	EMERGENCY	23,364	9,168	0	3,168	65,896	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,634	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	358,966	98,881	14,532	20,809	328,243	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,344	14,415	0	2,177	0	192.00
192.01	19201	PEDIATRICS	0	1,869	0	560	0	192.01
192.02	19202	BROOKVILLE	0	0	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	303	0	299	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	1,206	0	646	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	95	1,974	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
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)	362,554	2,216,318	270,837	1,840,479	919,916	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.979055	18.995817	18.637283	74.858822	2.785792	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,456	154,416	40,381	309,566	20,673	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.265875	1.323483	2.778764	12.591149	0.062604	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 2/13/2020 2:38 pm

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
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	100				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	760		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	500		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	56		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	102		54.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	6		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	28		90.00
90.01	09001	WOUND CLINC	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	62		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	754		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6		192.00
192.01	19201	PEDIATRICS	0	0	0		192.01
192.02	19202	BROOKVILLE	0	0	0		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0		192.03
192.04	19204	ENT	0	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0		194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0		194.02
194.03	07953	EMS	0	0	0		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0		194.04
194.05	07955	MMHCB RHC	0	0	0		194.05
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)	75,205	5,645,534	3,077,072		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	752.050000	56,455.340000	4,048.778947		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,413	115,530	212,863		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	397.640000	1,155.300000	280.082895		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 2/13/2020 2:38 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,598,303		8,598,303	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	689,249		689,249	0	0	31.00
43.00	04300	NURSERY	1,258,297		1,258,297	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,648,172		3,648,172	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	369,551		369,551	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,955,049		14,955,049	0	0	54.00
60.00	06000	LABORATORY	5,899,315		5,899,315	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,413,539	0	1,413,539	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,384,780	0	2,384,780	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	693,316	0	693,316	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	422,383	0	422,383	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,543,436		1,543,436	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,175,144		4,175,144	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,520,666		1,520,666	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,645,534		5,645,534	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,898,827		1,898,827	0	0	88.00
90.00	09000	CLINIC	3,706,936		3,706,936	0	0	90.00
90.01	09001	WOUND CLINC	586,488		586,488	0	0	90.01
91.00	09100	EMERGENCY	5,652,097		5,652,097	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,367,353		1,367,353		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,238,622		3,238,622		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,635,371		1,635,371		0	116.00
200.00		Subtotal (see instructions)	71,302,428	0	71,302,428	0	0	200.00
201.00		Less Observation Beds	1,367,353		1,367,353		0	201.00
202.00		Total (see instructions)	69,935,075	0	69,935,075	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,627,786		5,627,786			30.00
31.00	03100	INTENSIVE CARE UNIT	661,178		661,178			31.00
43.00	04300	NURSERY	2,363,755		2,363,755			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,832,934	5,680,133	7,513,067	0.485577	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	184,441	43,374	227,815	1.622154	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,567,379	64,312,011	65,879,390	0.227006	0.000000	54.00
60.00	06000	LABORATORY	3,001,513	28,058,683	31,060,196	0.189932	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	2,559,459	1,157,362	3,716,821	0.380309	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	174,517	4,109,842	4,284,359	0.556625	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	102,627	1,236,595	1,339,222	0.517701	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	78,885	684,713	763,598	0.553148	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	392,035	4,473,360	4,865,395	0.317227	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,305,979	10,211,095	14,517,074	0.287602	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	880,404	848,745	1,729,149	0.879430	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,802,447	9,330,755	13,133,202	0.429867	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,129,275	1,129,275			88.00
90.00	09000	CLINIC	6,842	5,405,684	5,412,526	0.684881	0.000000	90.00
90.01	09001	WOUND CLINC	0	1,088,326	1,088,326	0.538890	0.000000	90.01
91.00	09100	EMERGENCY	477,244	11,584,479	12,061,723	0.468598	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,865	921,255	961,120	1.422666	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,778,083	1,778,083			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,335,386	2,335,386			116.00
200.00		Subtotal (see instructions)	28,059,290	154,389,156	182,448,446			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	28,059,290	154,389,156	182,448,446			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	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
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: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 2/13/2020 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,598,303		8,598,303	0	8,598,303	30.00
31.00	03100	INTENSIVE CARE UNIT	689,249		689,249	0	689,249	31.00
43.00	04300	NURSERY	1,258,297		1,258,297	0	1,258,297	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,648,172		3,648,172	0	3,648,172	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	369,551		369,551	0	369,551	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,955,049		14,955,049	0	14,955,049	54.00
60.00	06000	LABORATORY	5,899,315		5,899,315	0	5,899,315	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,413,539	0	1,413,539	0	1,413,539	65.00
66.00	06600	PHYSICAL THERAPY	2,384,780	0	2,384,780	0	2,384,780	66.00
67.00	06700	OCCUPATIONAL THERAPY	693,316	0	693,316	0	693,316	67.00
68.00	06800	SPEECH PATHOLOGY	422,383	0	422,383	0	422,383	68.00
69.00	06900	ELECTROCARDIOLOGY	1,543,436		1,543,436	0	1,543,436	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,175,144		4,175,144	0	4,175,144	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,520,666		1,520,666	0	1,520,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,645,534		5,645,534	0	5,645,534	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,898,827		1,898,827	0	1,898,827	88.00
90.00	09000	CLINIC	3,706,936		3,706,936	0	3,706,936	90.00
90.01	09001	WOUND CLINC	586,488		586,488	0	586,488	90.01
91.00	09100	EMERGENCY	5,652,097		5,652,097	0	5,652,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,367,353		1,367,353		1,367,353	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,238,622		3,238,622		3,238,622	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,635,371		1,635,371		1,635,371	116.00
200.00		Subtotal (see instructions)	71,302,428	0	71,302,428	0	71,302,428	200.00
201.00		Less Observation Beds	1,367,353		1,367,353		1,367,353	201.00
202.00		Total (see instructions)	69,935,075	0	69,935,075	0	69,935,075	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 2/13/2020 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,627,786		5,627,786			30.00
31.00	03100	INTENSIVE CARE UNIT	661,178		661,178			31.00
43.00	04300	NURSERY	2,363,755		2,363,755			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,832,934	5,680,133	7,513,067	0.485577	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	184,441	43,374	227,815	1.622154	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,567,379	64,312,011	65,879,390	0.227006	0.000000	54.00
60.00	06000	LABORATORY	3,001,513	28,058,683	31,060,196	0.189932	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	2,559,459	1,157,362	3,716,821	0.380309	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	174,517	4,109,842	4,284,359	0.556625	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	102,627	1,236,595	1,339,222	0.517701	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	78,885	684,713	763,598	0.553148	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	392,035	4,473,360	4,865,395	0.317227	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,305,979	10,211,095	14,517,074	0.287602	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	880,404	848,745	1,729,149	0.879430	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,802,447	9,330,755	13,133,202	0.429867	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,129,275	1,129,275	1.681457	0.000000	88.00
90.00	09000	CLINIC	6,842	5,405,684	5,412,526	0.684881	0.000000	90.00
90.01	09001	WOUND CLINC	0	1,088,326	1,088,326	0.538890	0.000000	90.01
91.00	09100	EMERGENCY	477,244	11,584,479	12,061,723	0.468598	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,865	921,255	961,120	1.422666	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,778,083	1,778,083			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,335,386	2,335,386			116.00
200.00		Subtotal (see instructions)	28,059,290	154,389,156	182,448,446			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	28,059,290	154,389,156	182,448,446			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 2/13/2020 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	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
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	340,835	7,513,067	0.045366	431,833	19,591	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,163	227,815	0.307982	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,251,254	65,879,390	0.018993	642,932	12,211	54.00
60.00	06000	LABORATORY	286,162	31,060,196	0.009213	1,167,601	10,757	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	168,602	3,716,821	0.045362	1,416,244	64,244	65.00
66.00	06600	PHYSICAL THERAPY	333,518	4,284,359	0.077845	102,475	7,977	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,483	1,339,222	0.052630	62,724	3,301	67.00
68.00	06800	SPEECH PATHOLOGY	62,030	763,598	0.081234	49,066	3,986	68.00
69.00	06900	ELECTROCARDIOLOGY	160,160	4,865,395	0.032918	218,549	7,194	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,010	14,517,074	0.005787	1,284,152	7,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	178,873	1,729,149	0.103446	436,264	45,130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,530	13,133,202	0.008797	1,515,965	13,336	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	98,714	1,129,275	0.087414	0	0	88.00
90.00	09000	CLINIC	839,187	5,412,526	0.155045	0	0	90.00
90.01	09001	WOUND CLINC	43,929	1,088,326	0.040364	0	0	90.01
91.00	09100	EMERGENCY	614,773	12,061,723	0.050969	78,523	4,002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	172,381	961,120	0.179354	659	118	92.00
200.00		Total (lines 50 through 199)	4,890,604	169,682,258		7,406,987	199,278	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINC	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	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: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,513,067	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	227,815	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	65,879,390	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	31,060,196	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,716,821	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,284,359	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,339,222	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	763,598	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,865,395	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,517,074	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,729,149	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,133,202	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,129,275	0.000000	88.00
90.00	09000	CLINIC	0	0	0	5,412,526	0.000000	90.00
90.01	09001	WOUND CLINC	0	0	0	1,088,326	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	12,061,723	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	961,120	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	169,682,258		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	431,833	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	642,932	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,167,601	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	1,416,244	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	102,475	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	62,724	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	49,066	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	218,549	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,284,152	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	436,264	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,515,965	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	78,523	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	659	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,406,987	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.485577	0	1,152,830	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.622154	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.227006	0	22,292,939	3,495	0	54.00
60.00	06000	LABORATORY	0.189932	0	8,198,049	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.380309	0	288,864	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.556625	0	956,792	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.517701	0	161,729	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.553148	0	15,649	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.317227	0	1,612,307	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.287602	0	2,722,525	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.879430	0	311,334	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429867	0	2,889,011	609	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.684881	0	1,557,082	31	0	90.00
90.01	09001	WOUND CLINC	0.538890	0	470,875	18	0	90.01
91.00	09100	EMERGENCY	0.468598	0	2,709,892	1,618	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.422666	0	463,755	0	0	92.00
200.00		Subtotal (see instructions)		0	45,803,633	5,771	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	45,803,633	5,771	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	559,788	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,060,631	793		54.00
60.00	06000	LABORATORY	1,557,072	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	109,858	0		65.00
66.00	06600	PHYSICAL THERAPY	532,574	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	83,727	0		67.00
68.00	06800	SPEECH PATHOLOGY	8,656	0		68.00
69.00	06900	ELECTROCARDIOLOGY	511,467	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	783,004	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	273,796	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,241,890	262		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	1,066,416	21		90.00
90.01	09001	WOUND CLINC	253,750	10		90.01
91.00	09100	EMERGENCY	1,269,850	758		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	659,768	0		92.00
200.00		Subtotal (see instructions)	13,972,247	1,844		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	13,972,247	1,844		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,213	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,213	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)	4,384	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)	0	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)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,631	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,598,303	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,598,303	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,598,303	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)	1,649.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,690,171	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,690,171	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	689,249	217	3,176.26	176	559,022	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)	2,744,381	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,993,574	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	829	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,649.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,367,353	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,083,980	8,598,303	0.126069	1,367,353	172,381	90.00
91.00	Nursing School cost	0	8,598,303	0.000000	1,367,353	0	91.00
92.00	Allied health cost	0	8,598,303	0.000000	1,367,353	0	92.00
93.00	All other Medical Education	0	8,598,303	0.000000	1,367,353	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 2/13/2020 2:38 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,213	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,213	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)	4,384	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)	0	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)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	51	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)	1,049	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)	8,598,303	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,598,303	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,598,303	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)	1,649.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	84,119	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)	84,119	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 2/13/2020 2:38 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,258,297	1,049	1,199.52	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	689,249	217	3,176.26	4	12,705	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)	116,025	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	212,849	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	829	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,649.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,367,353	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 2/13/2020 2:38 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,083,980	8,598,303	0.126069	1,367,353	172,381	90.00
91.00	Nursing School cost	0	8,598,303	0.000000	1,367,353	0	91.00
92.00	Allied health cost	0	8,598,303	0.000000	1,367,353	0	92.00
93.00	All other Medical Education	0	8,598,303	0.000000	1,367,353	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,758,417		30.00
31.00	03100	INTENSIVE CARE UNIT		341,298		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.485577	431,833	209,688	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.622154	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.227006	642,932	145,949	54.00
60.00	06000	LABORATORY	0.189932	1,167,601	221,765	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.380309	1,416,244	538,610	65.00
66.00	06600	PHYSICAL THERAPY	0.556625	102,475	57,040	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.517701	62,724	32,472	67.00
68.00	06800	SPEECH PATHOLOGY	0.553148	49,066	27,141	68.00
69.00	06900	ELECTROCARDIOLOGY	0.317227	218,549	69,330	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.287602	1,284,152	369,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.879430	436,264	383,664	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429867	1,515,965	651,663	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.684881	0	0	90.00
90.01	09001	WOUND CLINC	0.538890	0	0	90.01
91.00	09100	EMERGENCY	0.468598	78,523	36,796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.422666	659	938	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,406,987	2,744,381	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)		7,406,987		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 2/13/2020 2:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		17,643		30.00
31.00	03100	INTENSIVE CARE UNIT		3,744		31.00
43.00	04300	NURSERY		39,901		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.485577	13,248	6,433	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.622154	43,121	69,949	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.227006	11,597	2,633	54.00
60.00	06000	LABORATORY	0.189932	30,048	5,707	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.380309	18,194	6,919	65.00
66.00	06600	PHYSICAL THERAPY	0.556625	398	222	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.517701	143	74	67.00
68.00	06800	SPEECH PATHOLOGY	0.553148	339	188	68.00
69.00	06900	ELECTROCARDIOLOGY	0.317227	3,808	1,208	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.287602	16,848	4,846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.879430	3,158	2,777	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429867	24,711	10,622	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.681457	0	0	88.00
90.00	09000	CLINIC	0.684881	66	45	90.00
90.01	09001	WOUND CLINC	0.538890	0	0	90.01
91.00	09100	EMERGENCY	0.468598	9,395	4,402	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.422666	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		175,074	116,025	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)		175,074		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 2/13/2020 2:38 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	13,974,091	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)	13,974,091	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	14,113,832	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	121,029	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	7,529,027	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)	6,463,776	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)	6,463,776	30.00
31.00	Primary payer payments	4,646	31.00
32.00	Subtotal (line 30 minus line 31)	6,459,130	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)	852,522	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	554,139	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	384,364	36.00
37.00	Subtotal (see instructions)	7,013,269	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	7,013,269	40.00
40.01	Sequestration adjustment (see instructions)	140,265	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,607,787	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	265,217	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: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,351,301		6,545,640	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	08/14/2018	144,600	12/31/2019	62,147	3.01
3.02		12/31/2019	199,135		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)		343,735		62,147	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)		5,695,036		6,607,787	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		265,217	6.01
6.02	SETTLEMENT TO PROGRAM		276,965		0	6.02
7.00	Total Medicare program liability (see instructions)		5,418,071		6,873,004	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: 15-1329	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 2/13/2020 2:38 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 2/13/2020 2:38 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,993,574	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)	5,993,574	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	6,053,510	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)	6,053,510	19.00
20.00	Deductibles (exclude professional component)	554,736	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,498,774	22.00
23.00	Coinsurance	4,020	23.00
24.00	Subtotal (line 22 minus line 23)	5,494,754	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	52,139	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	33,890	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,149	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,528,644	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)	5,528,644	30.00
30.01	Sequestration adjustment (see instructions)	110,573	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	5,695,036	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)	-276,965	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: 15-1329	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 2/13/2020 2:38 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	212,849		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)	212,849	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)	212,849	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	61,289		8.00
9.00	Ancillary service charges	175,074	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)	236,363	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)	236,363	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	23,514	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)	212,849	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)	212,849	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)	212,849	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)	212,849	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	212,849	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)	212,849	0	40.00
41.00	Interim payments	195,739	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	17,110	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: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 2/13/2020 2:38 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,496,199	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	54,951,228	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-31,515,928	0	0	0	6.00
7.00	Inventory	1,355,219	0	0	0	7.00
8.00	Prepaid expenses	1,839,815	0	0	0	8.00
9.00	Other current assets	311,178	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)	28,437,711	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,419,583	0	0	0	12.00
13.00	Land improvements	272,044	0	0	0	13.00
14.00	Accumulated depreciation	-177,675	0	0	0	14.00
15.00	Buildings	79,896,265	0	0	0	15.00
16.00	Accumulated depreciation	-42,949,570	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,245,768	0	0	0	19.00
20.00	Accumulated depreciation	-5,119,044	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	57,327,432	0	0	0	23.00
24.00	Accumulated depreciation	-33,052,191	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)	63,862,612	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	71,470,580	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	71,470,580	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	163,770,903	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,712,903	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	9,260,156	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	3,051,850	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,024,909	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	23,823,994	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,823,994	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	43,848,903	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	119,922,000				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)	119,922,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	163,770,903	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 2/13/2020 2:38 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		127,963,057		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,041,208				2.00
3.00	Total (sum of line 1 and line 2)		119,921,849		0		3.00
4.00	MISC	151		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)		151		0		10.00
11.00	Subtotal (line 3 plus line 10)		119,922,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		119,922,000		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	MISC		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/13/2020 2:38 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,991,540		7,991,540	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)	7,991,540		7,991,540	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	661,178		661,178	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)	661,178		661,178	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,652,718		8,652,718	17.00
18.00	Ancillary services	18,882,619	130,146,667	149,029,286	18.00
19.00	Outpatient services	522,681	19,001,014	19,523,695	19.00
20.00	RURAL HEALTH CLINIC	0	1,129,275	1,129,275	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,778,083	1,778,083	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	2,335,386	2,335,386	26.00
27.00	NON-PROVIDER BASED	206	8,788,307	8,788,513	27.00
27.01	PROFESSIONAL FEES	2,165,215	22,958,836	25,124,051	27.01
27.02	DIETARY	0	8,692	8,692	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	30,223,439	186,146,260	216,369,699	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		107,331,601		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)		107,331,601		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 2/13/2020 2:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	216,369,699	1.00
2.00	Less contractual allowances and discounts on patients' accounts	115,769,341	2.00
3.00	Net patient revenues (line 1 minus line 2)	100,600,358	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	107,331,601	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,731,243	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	1,397,789	24.00
24.01	CONTRIBUTIONS	461,900	24.01
24.02	GAIN ON DISPOSAL	17,099	24.02
24.03	INVESTMENT RETURN	3,670,726	24.03
24.04	UNREALIZED GAIN, DERIVATIVE	399,170	24.04
24.05	TEMPORARILY RESTRICTED ASSETS	12,504	24.05
24.06	UNREALIZED GAIN, INVESTMENTS	-7,135,078	24.06
24.07	DONATION OF LAND	-134,075	24.07
25.00	Total other income (sum of lines 6-24)	-1,309,965	25.00
26.00	Total (line 5 plus line 25)	-8,041,208	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)	-8,041,208	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1329 HHA CCN: 15-7143 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H | Date/Time Prepared: 2/13/2020 2:38 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	470,055	0	0	0	233,843	703,898	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	575,672	0	0	0	0	575,672	6.00
7.00	Physical Therapy	485,589	0	0	0	0	485,589	7.00
8.00	Occupational Therapy	169,230	0	0	0	0	169,230	8.00
9.00	Speech Pathology	3,651	0	0	0	0	3,651	9.00
10.00	Medical Social Services	13,683	0	0	0	0	13,683	10.00
11.00	Home Health Aide	34,920	0	0	0	0	34,920	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	597	0	0	0	0	597	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)	1,753,397	0	0	0	233,843	1,987,240	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	-66,658	637,240	0	637,240			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	575,672	0	575,672			6.00
7.00	Physical Therapy	0	485,589	0	485,589			7.00
8.00	Occupational Therapy	0	169,230	0	169,230			8.00
9.00	Speech Pathology	0	3,651	0	3,651			9.00
10.00	Medical Social Services	0	13,683	0	13,683			10.00
11.00	Home Health Aide	0	34,920	0	34,920			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	597	0	597			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)	-66,658	1,920,582	0	1,920,582			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: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	637,240	0	0	0	0	637,240	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	575,672	0	0	0	0	575,672	6.00
7.00	Physical Therapy	485,589	0	0	0	0	485,589	7.00
8.00	Occupational Therapy	169,230	0	0	0	0	169,230	8.00
9.00	Speech Pathology	3,651	0	0	0	0	3,651	9.00
10.00	Medical Social Services	13,683	0	0	0	0	13,683	10.00
11.00	Home Health Aide	34,920	0	0	0	0	34,920	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	597	0	0	0	0	597	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)	1,920,582	0	0	0	0	1,920,582	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	637,240		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	285,849	861,521	6.00
7.00	Physical Therapy	241,118	726,707	7.00
8.00	Occupational Therapy	84,031	253,261	8.00
9.00	Speech Pathology	1,813	5,464	9.00
10.00	Medical Social Services	6,794	20,477	10.00
11.00	Home Health Aide	17,339	52,259	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	296	893	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)		1,920,582	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part II Date/Time Prepared: 2/13/2020 2:38 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-637,240	1,283,342	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	575,672	6.00
7.00	Physical Therapy	0	0	0	0	0	485,589	7.00
8.00	Occupational Therapy	0	0	0	0	0	169,230	8.00
9.00	Speech Pathology	0	0	0	0	0	3,651	9.00
10.00	Medical Social Services	0	0	0	0	0	13,683	10.00
11.00	Home Health Aide	0	0	0	0	0	34,920	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	597	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	-637,240	1,283,342	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		637,240	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.496547	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-2 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT		
		0	1.00	1.01	2.00	2.01	4.00	
1.00	Administrative and General	0	50,522	2,345	93,671	1,003	486,803	1.00
2.00	Skilled Nursing Care	861,521	0	0	0	0	0	2.00
3.00	Physical Therapy	726,707	0	0	0	0	0	3.00
4.00	Occupational Therapy	253,261	0	0	0	0	0	4.00
5.00	Speech Pathology	5,464	0	0	0	0	0	5.00
6.00	Medical Social Services	20,477	0	0	0	0	0	6.00
7.00	Home Health Aide	52,259	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	893	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)	1,920,582	50,522	2,345	93,671	1,003	486,803	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	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	
		4A	5.00	7.00	7.01	7.02	8.00	
1.00	Administrative and General	634,344	124,156	95,621	968	18,016	0	1.00
2.00	Skilled Nursing Care	861,521	168,621	0	0	0	0	2.00
3.00	Physical Therapy	726,707	142,234	0	0	0	0	3.00
4.00	Occupational Therapy	253,261	49,569	0	0	0	0	4.00
5.00	Speech Pathology	5,464	1,069	0	0	0	0	5.00
6.00	Medical Social Services	20,477	4,008	0	0	0	0	6.00
7.00	Home Health Aide	52,259	10,228	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	893	175	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,554,926	500,060	95,621	968	18,016	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.	0.000000						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: 15-1329 HHA CCN: 15-7143 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-2 Part I Date/Time Prepared: 2/13/2020 2:38 pm

Home Health Agency I | PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	69,031	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	69,031	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	942,136	0	942,136			1.00
2.00	Skilled Nursing Care	0	1,030,142	0	1,030,142	422,618	1,452,760	2.00
3.00	Physical Therapy	0	868,941	0	868,941	356,484	1,225,425	3.00
4.00	Occupational Therapy	0	302,830	0	302,830	124,236	427,066	4.00
5.00	Speech Pathology	0	6,533	0	6,533	2,680	9,213	5.00
6.00	Medical Social Services	0	24,485	0	24,485	10,045	34,530	6.00
7.00	Home Health Aide	0	62,487	0	62,487	25,635	88,122	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	1,068	0	1,068	438	1,506	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	3,238,622	0	3,238,622	942,136	3,238,622	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.					0.410251		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: 15-1329 HHA CCN: 15-7143

Period: From 01/01/2018 To 12/31/2018

Worksheet H-2 Part II Date/Time Prepared: 2/13/2020 2:38 pm

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	Cost Center Description	CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		1.00	1.01	2.00	2.01	4.00	5A	
1.00	Administrative and General	3,415	219	3,415	219	1,753,398	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)	3,415	219	3,415	219	1,753,398		20.00
21.00	Total cost to be allocated	50,522	2,345	93,671	1,003	486,803		21.00
22.00	Unit cost multiplier	14.794143	10.707763	27.429283	4.579909	0.277634		22.00

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.00	7.00	7.01	7.02	8.00	9.00	
1.00	Administrative and General	634,344	3,415	219	3,634	0	3,634	1.00
2.00	Skilled Nursing Care	861,521	0	0	0	0	0	2.00
3.00	Physical Therapy	726,707	0	0	0	0	0	3.00
4.00	Occupational Therapy	253,261	0	0	0	0	0	4.00
5.00	Speech Pathology	5,464	0	0	0	0	0	5.00
6.00	Medical Social Services	20,477	0	0	0	0	0	6.00
7.00	Home Health Aide	52,259	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	893	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)	2,554,926	3,415	219	3,634	0	3,634	20.00
21.00	Total cost to be allocated	500,060	95,621	968	18,016	0	69,031	21.00
22.00	Unit cost multiplier	0.195724	28.000293	4.420091	4.957622	0.000000	18.995872	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1329
HHA CCN: 15-7143

Period: From 01/01/2018 To 12/31/2018

Worksheet H-2 Part II
Date/Time Prepared: 2/13/2020 2:38 pm

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,452,760		1,452,760	5,342	271.95	1.00
2.00	Physical Therapy	3.00	1,225,425	0	1,225,425	2,934	417.66	2.00
3.00	Occupational Therapy	4.00	427,066	0	427,066	1,171	364.70	3.00
4.00	Speech Pathology	5.00	9,213	0	9,213	61	151.03	4.00
5.00	Medical Social Services	6.00	34,530		34,530	10	3,453.00	5.00
6.00	Home Health Aide	7.00	88,122		88,122	1,042	84.57	6.00
7.00	Total (sum of lines 1-6)		3,237,116	0	3,237,116	10,560		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	2,395			8.00
8.01	Skilled Nursing Care		17140	0	258			8.01
9.00	Physical Therapy		99915	0	1,440			9.00
9.01	Physical Therapy		17140	0	131			9.01
10.00	Occupational Therapy		99915	0	622			10.00
10.01	Occupational Therapy		17140	0	31			10.01
11.00	Speech Pathology		99915	0	42			11.00
11.01	Speech Pathology		17140	0	0			11.01
12.00	Medical Social Services		99915	0	4			12.00
12.01	Medical Social Services		17140	0	0			12.01
13.00	Home Health Aide		99915	0	452			13.00
13.01	Home Health Aide		17140	0	187			13.01
14.00	Total (sum of lines 8-13)			0	5,562			14.00

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

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,653		0	721,483		1.00
2.00	Physical Therapy	0	1,571		0	656,144		2.00
3.00	Occupational Therapy	0	653		0	238,149		3.00
4.00	Speech Pathology	0	42		0	6,343		4.00
5.00	Medical Social Services	0	4		0	13,812		5.00
6.00	Home Health Aide	0	639		0	54,040		6.00
7.00	Total (sum of lines 1-6)	0	5,562		0	1,689,971		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1329 HHA CCN: 15-7143 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs	0	0	0		0	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	721,483	1.00
2.00	Physical Therapy	656,144	2.00
3.00	Occupational Therapy	238,149	3.00
4.00	Speech Pathology	6,343	4.00
5.00	Medical Social Services	13,812	5.00
6.00	Home Health Aide	54,040	6.00
7.00	Total (sum of lines 1-6)	1,689,971	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part II | Date/Time Prepared: 2/13/2020 2:38 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.556625	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.517701	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.553148	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.287602	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.429867	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329 HHA CCN: 15-7143	Period: From 01/01/2018 To 12/31/2018	Worksheet H-4 Part I-II Date/Time Prepared: 2/13/2020 2:38 pm
	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	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	652,517	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	177,541	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	14,676	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,100	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	57,824	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	3,112	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	908,770	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	908,770	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	908,770	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	908,770	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	908,770	31.00
31.01	Sequestration adjustment (see instructions)	0	18,175	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	890,595	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: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-5 | Date/Time Prepared: 2/13/2020 2:38 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		890,595	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		890,595	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		890,595	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: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O | Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	174,868	147,958	322,826	-14,579	308,247	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	12,363	12,363	0	12,363	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	70,533	70,533	0	70,533	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	142,371	142,371	0	142,371	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	14,400	14,400	0	14,400	26.00
27.00	NURSE PRACTITIONER**	1,167	0	1,167	0	1,167	27.00
28.00	REGISTERED NURSE**	383,995	0	383,995	0	383,995	28.00
29.00	LPN/LVN**	16,851	0	16,851	0	16,851	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	63,931	0	63,931	0	63,931	33.00
34.00	SPIRITUAL COUNSELING**	31,398	0	31,398	0	31,398	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**	106,290	0	106,290	0	106,290	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	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	778,500	387,625	1,166,125	-14,579	1,151,546	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: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O | Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	308,247		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	12,363		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	70,533		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	142,371		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	14,400		26.00
27.00	NURSE PRACTITIONER**	0	1,167		27.00
28.00	REGISTERED NURSE**	0	383,995		28.00
29.00	LPN/LVN**	0	16,851		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	63,931		33.00
34.00	SPIRITUAL COUNSELING**	0	31,398		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	106,290		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	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	1,151,546		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: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-2 | Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	14,400	14,400	0	14,400	26.00
27.00	NURSE PRACTITIONER	1,166	0	1,166	0	1,166	27.00
28.00	REGISTERED NURSE	383,654	0	383,654	0	383,654	28.00
29.00	LPN/LVN	16,836	0	16,836	0	16,836	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	63,874	0	63,874	0	63,874	33.00
34.00	SPIRITUAL COUNSELING	31,370	0	31,370	0	31,370	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	106,195	0	106,195	0	106,195	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	603,095	14,400	617,495	0	617,495	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	14,400		26.00
27.00	NURSE PRACTITIONER	0	1,166		27.00
28.00	REGISTERED NURSE	0	383,654		28.00
29.00	LPN/LVN	0	16,836		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	63,874		33.00
34.00	SPIRITUAL COUNSELING	0	31,370		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	106,195		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	617,495		100.00

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

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

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-3 | Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	136	0	136	0	136	28.00
29.00	LPN/LVN	6	0	6	0	6	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	23	0	23	0	23	33.00
34.00	SPIRITUAL COUNSELING	11	0	11	0	11	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	38	0	38	0	38	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	214	0	214	0	214	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	136		28.00
29.00	LPN/LVN	0	6		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	23		33.00
34.00	SPIRITUAL COUNSELING	0	11		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	38		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	214		100.00

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

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

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-4 | Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	1	0	1	0	1	27.00
28.00	REGISTERED NURSE	205	0	205	0	205	28.00
29.00	LPN/LVN	9	0	9	0	9	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	34	0	34	0	34	33.00
34.00	SPIRITUAL COUNSELING	17	0	17	0	17	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	57	0	57	0	57	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	323	0	323	0	323	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	1		27.00
28.00	REGISTERED NURSE	0	205		28.00
29.00	LPN/LVN	0	9		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	34		33.00
34.00	SPIRITUAL COUNSELING	0	17		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	57		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	323		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: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-5 | Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	216,137	216,137	3.00
4.00	ADMINISTRATIVE & GENERAL	308,247	267,688	575,935	4.00
5.00	PLANT OPERATION & MAINTENANCE	12,363	0	12,363	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	70,533		70,533	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	142,371	0	142,371	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	617,495		617,495	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	214		214	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	323		323	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	1,151,546	483,825	1,635,371	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part I Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	216,137	0	0	216,137		3.00
4.00	ADMINISTRATIVE & GENERAL	575,935	0	0	0	575,935	4.00
5.00	PLANT OPERATION & MAINTENANCE	12,363	0	0	0	12,363	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	70,533	0	0	0	70,533	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	142,371	0	0	0	142,371	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	617,495			215,945	833,440	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	214	0	0	77	291	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	323	0	0	115	438	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	1,635,371	0	0	216,137	1,635,371	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	575,935					4.00
5.00	PLANT OPERATION & MAINTENANCE	6,721	19,084				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	38,343	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	77,396	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	453,079					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	158	7,634	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	238	11,450	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	575,935	19,084	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part I Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			108,876		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	108,779	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	39	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	58	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	108,876	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part I | Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	219,767					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	219,571	0	0		1,614,869	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	79	0	0	0	8,201	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	117	0	0	0	12,301	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	219,767	0	0	0	1,635,371	100.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

Period:
From 01/01/2018
To 12/31/2018

Worksheet O-6
Part II
Date/Time Prepared:
2/13/2020 2:38 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	216,175			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-575,935	1,059,436	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	12,363	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	70,533	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	142,371	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			215,983	0	833,440	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	77	0	291	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	115	0	438	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	0	216,137		575,935	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.999824		0.543624	101.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

Period:
From 01/01/2018
To 12/31/2018

Worksheet O-6
Part II
Date/Time Prepared:
2/13/2020 2:38 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	19,195					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7,678	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	11,517	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	19,084	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.994217	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

Period: From 01/01/2018 To 12/31/2018

Worksheet O-6
Part II
Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			109,553			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	221,134	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	0	109,456	0	220,937	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	39	0	79	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	58	0	118	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)	0	0	108,876	0	219,767	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.993820	0.000000	0.993818	101.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

Period:
From 01/01/2018
To 12/31/2018

Worksheet O-6
Part II
Date/Time Prepared:
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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: 15-1329 Hospice CCN: 15-1551

Period: From 01/01/2018 To 12/31/2018

Worksheet O-7

Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.556625	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.517701	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.553148	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.429867	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.189932	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.287602	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	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
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	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	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
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-8 | Date/Time Prepared: 2/13/2020 2:38 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,614,869	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			11,255	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			143.48	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	9,441	211		9.00
10.00	Program cost (line 8 times line 9)	1,354,595	30,274		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)			8,201	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			4	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			2,050.25	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)			12,301	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			6	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			2,050.17	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)			1,635,371	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			11,265	22.00
23.00	Average cost per diem (line 21 divided by line 22)			145.17	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 2/13/2020 2:38 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	157,293	0	157,293	0	157,293	1.00
2.00	Physician Assistant	120,483	0	120,483	0	120,483	2.00
3.00	Nurse Practitioner	274,684	0	274,684	0	274,684	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	104,388	0	104,388	0	104,388	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	256,388	0	256,388	0	256,388	9.00
10.00	Subtotal (sum of lines 1 through 9)	913,236	0	913,236	0	913,236	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	913,236	0	913,236	0	913,236	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	44,468	44,468	0	44,468	29.00
30.00	Administrative Costs	178,147	52,854	231,001	0	231,001	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	178,147	97,322	275,469	0	275,469	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,091,383	97,322	1,188,705	0	1,188,705	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 2/13/2020 2:38 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	157,293		1.00
2.00	Physician Assistant	0	120,483		2.00
3.00	Nurse Practitioner	0	274,684		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	104,388		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	256,388		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	913,236		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	913,236		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	44,468		29.00
30.00	Administrative Costs	0	231,001		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	275,469		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,188,705		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 2/13/2020 2:38 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.60	1,457	4,200	2,520		1.00
2.00	Physician Assistant	0.79	1,725	2,100	1,659		2.00
3.00	Nurse Practitioner	1.85	4,099	2,100	3,885		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.24	7,281		8,064	8,064	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.24	7,281			8,064	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					913,236	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					913,236	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					275,469	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					710,122	15.00
16.00	Total overhead (sum of lines 14 and 15)					985,591	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					985,591	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					985,591	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,898,827	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 2/13/2020 2:38 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,898,827	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			105,937	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,792,890	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,064	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			8,064	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			222.33	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	222.33	222.33		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,429		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	317,710		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	317,710		16.00
16.01	Total program charges (see instructions)(from contractor's records)		203,337		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,889		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,764		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		224,843		16.04
16.05	Total program cost (see instructions)	0	235,607		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,892		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		34,111		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		235,607		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		53,920		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		289,527		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		289,527		26.00
26.01	Sequestration adjustment (see instructions)		5,791		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		283,736		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		0		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 2/13/2020 2:38 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	913,236	913,236	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001511	0.004581	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,380	4,184	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	27,787	17,599	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	29,167	21,783	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	913,236	913,236	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	985,591	985,591	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.031938	0.023853	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	31,478	23,509	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	60,645	45,292	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	92	279	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	659.18	162.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	52	121	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	34,277	19,643	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		105,937	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		53,920	16.00

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

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-5 | Date/Time Prepared: 2/13/2020 2:38 pm

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		203,509	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		12/31/2019	80,227	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		80,227	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		283,736	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		283,736	7.00

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