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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0042	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 4:14 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 4:14 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOOD SAMARITAN HOSPITAL (15-0042) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-3,159	40,448	0	0	1.00
2.00	Subprovider - IPF	0	6,095	1,582		0	2.00
3.00	Subprovider - IRF	0	-10,595	-55		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
200.00	Total	0	-7,659	41,975	0	0	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: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 4:14 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 520 SOUTH 7TH STREET	PO Box:			1.00
2.00	City: VINCENNES	State: IN	Zip Code: 47591	County: KNOX	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	GOOD SAMARITAN HOSPITAL	150042	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	GOOD SAMARITAN HOSPITAL	15S042	99915	4	01/01/1984	N	P	O	4.00
5.00	Subprovider - IRF	GOOD SAMARITAN - REHAB	15T042	99915	5	01/01/2001	N	P	O	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	GOOD SAMARITAN HOME CARE	157432	99915		06/27/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	GOOD SAMARITAN LINCOLN TRAIL HOSPICE	151526	99915		01/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	258	98	365	419	2,264	45	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.	10	0	0	45	232		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 4:14 pm

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

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.02

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 4:14 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.	Y			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)	N	N	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.	Y			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)	N	N	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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	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.	N	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.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		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

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		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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,280,030	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: 15-0042	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 4:14 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)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0042	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 4:14 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: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2018 4:14 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	05/17/2018	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.	Y		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	04/11/2018	Y	04/11/2018	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: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 4:14 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BOB		BRANDENBURG		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173833787		BBRANDENBURG@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0042	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 4:14 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.	PARTNER		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: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 4:14 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	93	35,217	0.00	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)		93	35,217	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,950	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		123	46,167	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	22	8,030		0	16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,125		0	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		170				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: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 4:14 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)	11,405	161	13,817			1.00
2.00	HMO and other (see instructions)	1,052	3,146				2.00
3.00	HMO IPF Subprovider	69	0				3.00
4.00	HMO IRF Subprovider	101	277				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)	11,405	161	13,817			7.00
8.00	INTENSIVE CARE UNIT	1,436	85	7,286			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		12	1,003			13.00
14.00	Total (see instructions)	12,841	258	22,106	0.00	1,544.15	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,626	0	4,366	0.00	31.96	16.00
17.00	SUBPROVIDER - IRF	6,464	10	7,587	0.00	58.30	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	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	489	17	698	0.00	9.28	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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	1,643.69	27.00
28.00	Observation Bed Days		963	5,070			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	45	80			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: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 4:14 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	3,085	722	5,393	1.00
2.00	HMO and other (see instructions)			223	0		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	3,085	722	5,393	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	223	361	808	16.00
17.00	SUBPROVIDER - IRF	0.00	0	509	16	614	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						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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2018 4:14 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	106,214,408	0	106,214,408	3,418,872.60	31.07	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		179,853	0	179,853	1,986.00	90.56	3.00
4.00	Physician-Part A - Administrative		377,740	0	377,740	1,846.50	204.57	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		5,024,079	0	5,024,079	27,879.56	180.21	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		30,769,916	3,521,701	34,291,617	792,897.24	43.25	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		805,324	0	805,324	5,180.00	155.47	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		411,340	0	411,340	3,642.00	112.94	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		20,128,232	0	20,128,232			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		7,956,812	0	7,956,812			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		31,657	0	31,657			21.00
22.00	Physician Part A - Administrative		56,894	0	56,894			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		771,534	0	771,534			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II | Date/Time Prepared: 5/29/2018 4:14 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	5,150,329	0	5,150,329	283,449.88	18.17	26.00
27.00	Administrative & General	5.00	7,815,754	1,123,947	8,939,701	276,367.33	32.35	27.00
28.00	Administrative & General under contract (see inst.)		127,215	0	127,215	798.30	159.36	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,152,468	224,789	2,377,257	103,205.92	23.03	30.00
31.00	Laundry & Linen Service	8.00	205,383	0	205,383	15,536.36	13.22	31.00
32.00	Housekeeping	9.00	2,060,725	0	2,060,725	145,333.25	14.18	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,494,263	-1,116,678	377,585	24,380.09	15.49	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,116,678	1,116,678	72,101.00	15.49	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,462,988	74,930	1,537,918	36,955.65	41.62	38.00
39.00	Central Services and Supply	14.00	376,541	0	376,541	23,821.00	15.81	39.00
40.00	Pharmacy	15.00	2,872,278	0	2,872,278	69,509.91	41.32	40.00
41.00	Medical Records & Medical Records Library	16.00	2,381,472	0	2,381,472	108,060.76	22.04	41.00
42.00	Social Service	17.00	7,492,980	-4,945,367	2,547,613	94,796.03	26.87	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2018 4:14 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		101,137,691	0	101,137,691	3,389,805.34	29.84	1.00
2.00	Excluded area salaries (see instructions)		30,769,916	3,521,701	34,291,617	792,897.24	43.25	2.00
3.00	Subtotal salaries (line 1 minus line 2)		70,367,775	-3,521,701	66,846,074	2,596,908.10	25.74	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,216,664	0	1,216,664	8,822.00	137.91	4.00
5.00	Subtotal wage-related costs (see inst.)		20,185,126	0	20,185,126	0.00	30.20	5.00
6.00	Total (sum of lines 3 thru 5)		91,769,565	-3,521,701	88,247,864	2,605,730.10	33.87	6.00
7.00	Total overhead cost (see instructions)		33,592,396	-3,521,701	30,070,695	1,254,315.48	23.97	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2018 4:14 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	6,276,976	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	14,381,823	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	329,719	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	199,586	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	348,267	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	33,302	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	5,353,025	17.00
18.00	Medicare Taxes - Employers Portion Only	1,501,408	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	47,798	22.00
23.00	Tuition Reimbursement	473,225	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	28,945,129	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	805,324	28,945,129	1.00
2.00	Hospital	805,324	28,945,129	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0042 Hospice CCN: 15-1526

Period: From 01/01/2017 To 12/31/2017

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/29/2018 4:14 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	4,917	121	1,440	6,478	11.00
12.00	Hospice Inpatient Respite Care	17	0	19	36	12.00
13.00	Hospice General Inpatient Care	472	17	173	662	13.00
14.00	Total Hospice Days	5,406	138	1,632	7,176	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: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/29/2018 4:14 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)	0.255231	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,800,928	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	7,004,818	5.00
6.00	Medicaid charges	51,513,036	6.00
7.00	Medicaid cost (line 1 times line 6)	13,147,724	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)	2,644,760	3,225,882	5,870,642	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	675,025	3,225,882	3,900,907	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)	675,025	3,225,882	3,900,907	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)	20,245,385	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	472,304	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	726,622	27.01
28.00	Non-Medicare bad debt expense (see instructions)	19,518,763	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	5,236,111	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	9,137,018	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,137,018	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	23,369,426	23,369,426	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		10,465,566	10,465,566	-10,249,215	216,351	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	640,992	1,193,646	1,834,638	28,249,929	30,084,567	4.00
4.01	00401	COMMUNICATIONS	278,932	90,995	369,927	-89,965	279,962	4.01
4.02	00402	PURCHASING & RECEIVING	699,780	655,978	1,355,758	-298,335	1,057,423	4.02
4.03	00403	REGISTRATION	1,181,628	451,908	1,633,536	-413,151	1,220,385	4.03
4.04	00404	PATIENT ACCOUNTS	2,348,997	2,694,652	5,043,649	-819,663	4,223,986	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	7,815,754	24,046,149	31,861,903	-4,290,711	27,571,192	5.00
7.00	00700	OPERATION OF PLANT	2,152,468	4,574,540	6,727,008	-680,577	6,046,431	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	205,383	383,890	589,273	-186,867	402,406	8.00
9.00	00900	HOUSEKEEPING	2,060,725	1,061,411	3,122,136	-843,793	2,278,343	9.00
10.00	01000	DIETARY	1,494,263	2,234,051	3,728,314	-2,976,363	751,951	10.00
11.00	01100	CAFETERIA	0	0	0	2,396,328	2,396,328	11.00
13.00	01300	NURSING ADMINISTRATION	1,462,988	900,412	2,363,400	-574,468	1,788,932	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	376,541	387,279	763,820	-220,692	543,128	14.00
15.00	01500	PHARMACY	2,872,278	15,071,245	17,943,523	-14,759,152	3,184,371	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,381,472	1,372,422	3,753,894	-845,028	2,908,866	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	7,492,980	3,048,746	10,541,726	-7,702,025	2,839,701	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	220,235	89,327	309,562	-69,828	239,734	23.00
23.01	02302	PARAMED ED PGRM-LAB	222,104	33,318	255,422	-39,024	216,398	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,712,862	1,934,280	6,647,142	-1,590,939	5,056,203	30.00
31.00	03100	INTENSIVE CARE UNIT	3,515,788	1,666,384	5,182,172	-1,356,461	3,825,711	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	918,727	918,727	40.00
41.00	04100	SUBPROVIDER - IRF	2,021,470	954,314	2,975,784	-660,277	2,315,507	41.00
43.00	04300	NURSERY	310,502	140,326	450,828	-113,397	337,431	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,819,495	6,315,351	8,134,846	-1,823,913	6,310,933	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	966,523	952,165	1,918,688	-707,922	1,210,766	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,220,261	603,071	1,823,332	-477,117	1,346,215	52.00
53.00	05300	ANESTHESIOLOGY	2,233,170	1,383,882	3,617,052	-3,617,052	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,349,460	5,321,413	9,670,873	-3,472,547	6,198,326	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,303,998	1,548,750	2,852,748	-962,213	1,890,535	55.00
60.00	06000	LABORATORY	2,348,968	5,104,029	7,452,997	-2,503,891	4,949,106	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,018,023	1,012,398	3,030,421	-946,141	2,084,280	65.00
66.00	06600	PHYSICAL THERAPY	3,538,111	1,102,697	4,640,808	-996,994	3,643,814	66.00
69.00	06900	ELECTROCARDIOLOGY	4,580,798	3,686,786	8,267,584	-3,077,176	5,190,408	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	329,145	268,638	597,783	-123,024	474,759	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,788,391	6,788,391	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,812,265	5,812,265	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,959,666	13,959,666	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,223,037	2,803,256	4,026,293	-2,067,857	1,958,436	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	673,861	673,861	-95,020	578,841	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,504,462	1,489,353	3,993,815	-924,625	3,069,190	90.00
90.01	09001	OUTPATIENT PSYCH	422,943	2,960,832	3,383,775	-2,034,103	1,349,672	90.01
91.00	09100	EMERGENCY	4,501,327	7,408,773	11,910,100	-1,609,038	10,301,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	80,438	93,982	174,420	-60,008	114,412	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		3,886,009	3,886,009	-3,886,009	0	113.00
116.00	11600	HOSPICE	500,449	489,339	989,788	-170,928	818,860	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,408,750	120,555,424	198,964,174	3,159,223	202,123,397	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,005,384	15,787,485	42,792,869	-5,954,108	36,838,761	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	19,843	19,843	0	19,843	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	182,275	738,330	920,605	-53,046	867,559	194.02
194.03	07953	MH RESIDENTIAL	369,936	146,010	515,946	-95,691	420,255	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	42,948	42,948	459	43,407	194.05
194.06	07956	FOUNDATION	129,918	916,183	1,046,101	-36,748	1,009,353	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 4:14 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	
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	118,145	229,257	347,402	2,979,911	3,327,313	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	106,214,408	138,435,480	244,649,888	0	244,649,888	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-688,183	22,681,243		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	216,351		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-449,654	29,634,913		4.00
4.01	00401	COMMUNICATIONS	0	279,962		4.01
4.02	00402	PURCHASING & RECEIVING	-398,556	658,867		4.02
4.03	00403	REGISTRATION	0	1,220,385		4.03
4.04	00404	PATIENT ACCOUNTS	-300,478	3,923,508		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-9,486,824	18,084,368		5.00
7.00	00700	OPERATION OF PLANT	-3,490	6,042,941		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-12,326	390,080		8.00
9.00	00900	HOUSEKEEPING	0	2,278,343		9.00
10.00	01000	DIETARY	-654,253	97,698		10.00
11.00	01100	CAFETERIA	-546,195	1,850,133		11.00
13.00	01300	NURSING ADMINISTRATION	-11,640	1,777,292		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-4,475	538,653		14.00
15.00	01500	PHARMACY	-1,529	3,182,842		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-63,253	2,845,613		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
17.01	01701	MENTAL HEALTH OVERHEAD	-754,918	2,084,783		17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	-26,705	213,029		23.00
23.01	02302	PARAMED ED PGRM-LAB	0	216,398		23.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,056,203		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,825,711		31.00
40.00	04000	SUBPROVIDER - IPF	0	918,727		40.00
41.00	04100	SUBPROVIDER - IRF	-927	2,314,580		41.00
43.00	04300	NURSERY	0	337,431		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,254,104	4,056,829		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	0	1,210,766		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	-135	1,346,080		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-312,780	5,885,546		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-169,342	1,721,193		55.00
60.00	06000	LABORATORY	-65,581	4,883,525		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	-52	2,084,228		65.00
66.00	06600	PHYSICAL THERAPY	-2,773	3,641,041		66.00
69.00	06900	ELECTROCARDIOLOGY	-1,990,761	3,199,647		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	474,759		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,788,391		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,812,265		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-381,398	13,578,268		73.00
75.00	07500	ASC (NON-DISTINCT PART)	-43,526	1,914,910		75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03950	INPATIENT DIALYSIS	-209,584	369,257		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-1,258,352	1,810,838		90.00
90.01	09001	OUTPATIENT PSYCH	-3,400	1,346,272		90.01
91.00	09100	EMERGENCY	-5,288,177	5,012,885		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	114,412		96.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	-71	818,789		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-25,383,442	176,739,955		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36,838,761		192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	19,843		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	867,559		194.02
194.03	07953	MH RESIDENTIAL	0	420,255		194.03
194.04	07954	UNUSED SPACE	0	0		194.04
194.05	07955	MOB	0	43,407		194.05
194.06	07956	FOUNDATION	0	1,009,353		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	3,327,313		194.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
200.00	TOTAL (SUM OF LINES 118 through 199)	-25,383,442	219,266,446		200.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 4:14 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,959,666	1.00
	0		0	13,959,666	
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,788,391	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,812,265	2.00
3.00	PHARMACY	15.00	0	1,891	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
	0		0	12,602,547	
	C - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	28,331,459	1.00
2.00	MOB	194.05	0	459	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
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 4:14 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
	0		0	28,331,918		
	D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,870,705		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,189		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	5,525		3.00
4.00		0.00	0	0		4.00
	0		0	3,891,419		
	E - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	19,049,895		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
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
	0		0	19,049,895		
	F - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	448,826		1.00
	0		0	448,826		
	G - MENTAL HEALTH OVERHEAD					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,123,947	128,862		1.00
2.00	OPERATION OF PLANT	7.00	224,789	25,772		2.00
3.00	NURSING ADMINISTRATION	13.00	74,930	8,591		3.00
4.00	SUBPROVIDER - IPF	40.00	824,228	94,499		4.00
5.00	COMMUNITY MENTAL HEALTH CENTER	194.09	2,697,473	309,269		5.00
	0		4,945,367	566,993		
	H - DIETARY					
1.00	CAFETERIA	11.00	1,116,678	1,279,650		1.00
	0		1,116,678	1,279,650		
	I - ANESTHESIOLOGY					
1.00	OPERATING ROOM	50.00	2,233,170	959,072		1.00
	TOTALS		2,233,170	959,072		
500.00	Grand Total: Increases		8,295,215	81,089,986		500.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 4:14 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	13,959,666	0		1.00
	0		0	13,959,666			
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	72,975	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	4	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	709	0		3.00
4.00	OPERATION OF PLANT	7.00	0	1,118	0		4.00
5.00	HOUSEKEEPING	9.00	0	60	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,906	0		6.00
7.00	MENTAL HEALTH OVERHEAD	17.01	0	3,445	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	88,857	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	115,786	0		9.00
10.00	SUBPROVIDER - IRF	41.00	0	12,140	0		10.00
11.00	NURSERY	43.00	0	8,184	0		11.00
12.00	OPERATING ROOM	50.00	0	3,860,970	0		12.00
13.00	ENDOSCOPY	51.01	0	226,006	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	17,991	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	845,727	0		15.00
16.00	RADIOLOGY - THERAPEUTIC	55.00	0	7,820	0		16.00
17.00	LABORATORY	60.00	0	1,578,729	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	275,989	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	30,064	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	1,391,319	0		20.00
21.00	NEURODIAGNOSTICS	70.01	0	2,206	0		21.00
22.00	ASC (NON-DISTINCT PART)	75.00	0	1,383,252	0		22.00
23.00	INPATIENT DIALYSIS	76.01	0	4,545	0		23.00
24.00	CLINIC	90.00	0	450,008	0		24.00
25.00	OUTPATIENT PSYCH	90.01	0	1,961,441	0		25.00
26.00	EMERGENCY	91.00	0	218,483	0		26.00
27.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	37,811	0		27.00
28.00	HOSPICE	116.00	0	4,002	0		28.00
	0		0	12,602,547			
	C - EMPLOYEE BENEFITS						
1.00	COMMUNICATIONS	4.01	0	89,254	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	279,769	0		2.00
3.00	REGISTRATION	4.03	0	400,595	0		3.00
4.00	PATIENT ACCOUNTS	4.04	0	785,161	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	2,239,619	0		5.00
6.00	OPERATION OF PLANT	7.00	0	665,567	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	94,218	0		7.00
8.00	HOUSEKEEPING	9.00	0	812,791	0		8.00
9.00	DIETARY	10.00	0	521,709	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	404,217	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	160,055	0		11.00
12.00	PHARMACY	15.00	0	759,575	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	832,834	0		13.00
14.00	MENTAL HEALTH OVERHEAD	17.01	0	2,075,755	0		14.00
15.00	PARAMED ED PGRM-RADIOLOGY	23.00	0	67,126	0		15.00
16.00	PARAMED ED PGRM-LAB	23.01	0	35,788	0		16.00
17.00	ADULTS & PEDIATRICS	30.00	0	1,272,614	0		17.00
18.00	INTENSIVE CARE UNIT	31.00	0	1,017,447	0		18.00
19.00	SUBPROVIDER - IRF	41.00	0	588,668	0		19.00
20.00	NURSERY	43.00	0	82,436	0		20.00
21.00	OPERATING ROOM	50.00	0	548,339	0		21.00
22.00	ENDOSCOPY	51.01	0	294,369	0		22.00
23.00	DELIVERY ROOM & LABOR ROOM	52.00	0	340,260	0		23.00
24.00	ANESTHESIOLOGY	53.00	0	424,810	0		24.00
25.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,189,776	0		25.00
26.00	RADIOLOGY - THERAPEUTIC	55.00	0	383,007	0		26.00
27.00	LABORATORY	60.00	0	785,572	0		27.00
28.00	RESPIRATORY THERAPY	65.00	0	590,834	0		28.00
29.00	PHYSICAL THERAPY	66.00	0	934,645	0		29.00
30.00	ELECTROCARDIOLOGY	69.00	0	1,017,138	0		30.00
31.00	NEURODIAGNOSTICS	70.01	0	82,139	0		31.00
32.00	ASC (NON-DISTINCT PART)	75.00	0	390,865	0		32.00
33.00	CLINIC	90.00	0	471,916	0		33.00
34.00	OUTPATIENT PSYCH	90.01	0	71,640	0		34.00
35.00	EMERGENCY	91.00	0	1,276,534	0		35.00
36.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	21,601	0		36.00
37.00	HOSPICE	116.00	0	156,851	0		37.00
38.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,954,108	0		38.00
39.00	MARKETING AND PUBLIC RELATIONS	194.02	0	53,046	0		39.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 4:14 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
40.00	MH RESIDENTIAL	194.03	0	95,691	0		40.00
41.00	FOUNDATION	194.06	0	36,748	0		41.00
42.00	COMMUNITY MENTAL HEALTH CENTER	194.09	0	26,831	0		42.00
	0		0	28,331,918			
	D - INTEREST EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,024	11		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,112	11		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,274	0		3.00
4.00	INTEREST EXPENSE	113.00	0	3,886,009	0		4.00
	0		0	3,891,419			
	E - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,262,380	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,555	0		2.00
3.00	COMMUNICATIONS	4.01	0	711	0		3.00
4.00	PURCHASING & RECEIVING	4.02	0	18,562	0		4.00
5.00	REGISTRATION	4.03	0	12,556	0		5.00
6.00	PATIENT ACCOUNTS	4.04	0	34,502	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	0	2,859,891	0		7.00
8.00	OPERATION OF PLANT	7.00	0	264,453	0		8.00
9.00	LAUNDRY & LINEN SERVICE	8.00	0	92,649	0		9.00
10.00	HOUSEKEEPING	9.00	0	30,942	0		10.00
11.00	DIETARY	10.00	0	58,326	0		11.00
12.00	NURSING ADMINISTRATION	13.00	0	253,772	0		12.00
13.00	CENTRAL SERVICES & SUPPLY	14.00	0	57,731	0		13.00
14.00	PHARMACY	15.00	0	41,802	0		14.00
15.00	MEDICAL RECORDS & LIBRARY	16.00	0	12,194	0		15.00
16.00	MENTAL HEALTH OVERHEAD	17.01	0	110,465	0		16.00
17.00	PARAMED ED PGRM-RADIOLOGY	23.00	0	2,702	0		17.00
18.00	PARAMED ED PGRM-LAB	23.01	0	3,236	0		18.00
19.00	ADULTS & PEDIATRICS	30.00	0	229,468	0		19.00
20.00	INTENSIVE CARE UNIT	31.00	0	223,228	0		20.00
21.00	SUBPROVIDER - IRF	41.00	0	59,469	0		21.00
22.00	NURSERY	43.00	0	22,777	0		22.00
23.00	OPERATING ROOM	50.00	0	606,846	0		23.00
24.00	ENDOSCOPY	51.01	0	187,547	0		24.00
25.00	DELIVERY ROOM & LABOR ROOM	52.00	0	117,754	0		25.00
26.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,434,770	0		26.00
27.00	RADIOLOGY - THERAPEUTIC	55.00	0	571,386	0		27.00
28.00	LABORATORY	60.00	0	139,590	0		28.00
29.00	RESPIRATORY THERAPY	65.00	0	79,318	0		29.00
30.00	PHYSICAL THERAPY	66.00	0	32,285	0		30.00
31.00	ELECTROCARDIOLOGY	69.00	0	668,719	0		31.00
32.00	NEURODIAGNOSTICS	70.01	0	38,679	0		32.00
33.00	ASC (NON-DISTINCT PART)	75.00	0	293,740	0		33.00
34.00	INPATIENT DIALYSIS	76.01	0	90,475	0		34.00
35.00	CLINIC	90.00	0	2,701	0		35.00
36.00	OUTPATIENT PSYCH	90.01	0	1,022	0		36.00
37.00	EMERGENCY	91.00	0	114,021	0		37.00
38.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	596	0		38.00
39.00	HOSPICE	116.00	0	10,075	0		39.00
	0		0	19,049,895			
	F - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	448,826	12		1.00
	0		0	448,826			
	G - MENTAL HEALTH OVERHEAD						
1.00	MENTAL HEALTH OVERHEAD	17.01	4,945,367	566,993	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		4,945,367	566,993			
	H - DIETARY						
1.00	DIETARY	10.00	1,116,678	1,279,650	0		1.00
	0		1,116,678	1,279,650			
	I - ANESTHESIOLOGY						
1.00	ANESTHESIOLOGY	53.00	2,233,170	959,072	0		1.00
	TOTALS		2,233,170	959,072			
500.00	Grand Total: Decreases		8,295,215	81,089,986			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2018 4:14 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	6,912,648	0	0	0	0	1.00
2.00	Land Improvements	9,275,750	2,300,347	0	2,300,347	130,808	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	126,601,969	41,303,259	0	41,303,259	7,281,570	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	254,323,639	34,908,212	0	34,908,212	71,263,828	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	397,114,006	78,511,818	0	78,511,818	78,676,206	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	397,114,006	78,511,818	0	78,511,818	78,676,206	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	6,912,648	0	1.00
2.00	Land Improvements	11,445,289	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	160,623,658	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	217,968,023	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	396,949,618	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	396,949,618	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,465,566	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,465,566	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,465,566		2.00
3.00	Total (sum of lines 1-2)	0	10,465,566		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	178,981,595	0	178,981,595	0.450892	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	217,968,023	0	217,968,023	0.549108	0	2.00
3.00	Total (sum of lines 1-2)	396,949,618	0	396,949,618	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	19,049,895	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	203,186	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,253,081	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	CAP REL COSTS-BLDG & FIXT	3,182,522	448,826	0	0	22,681,243	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,165	0	0	0	216,351	2.00
3.00	Total (sum of lines 1-2)	3,195,687	448,826	0	0	22,897,594	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-131,972	PURCHASING & RECEIVING	4.02	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)	B	-28,201	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-12,070,369			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	B	-546,195	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-380,931	DRUGS CHARGED TO PATIENTS	73.00	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-581,418	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER MISC FEES	B	-10,996	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PURCHASE DISCOUNT	B	-68,146	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	RENTAL	B	-980	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	MISC INCOME	B	-266,584	PURCHASING & RECEIVING	4.02	0	33.04
33.05	MISC INCOME	B	-12,851	PATIENT ACCOUNTS	4.04	0	33.05
33.06	MISC INCOME	B	-3,490	OPERATION OF PLANT	7.00	0	33.06
33.07	MISC INCOME	B	-12,326	LAUNDRY & LINEN SERVICE	8.00	0	33.07
33.08	MISC INCOME	B	-11,640	NURSING ADMINISTRATION	13.00	0	33.08
33.09	MISC INCOME	B	-4,475	CENTRAL SERVICES & SUPPLY	14.00	0	33.09
33.10	MISC INCOME	B	-63,253	MEDICAL RECORDS & LIBRARY	16.00	0	33.10
33.11	MISC INCOME	B	-89,708	MENTAL HEALTH OVERHEAD	17.01	0	33.11
33.12	MISC INCOME	B	-21	MENTAL HEALTH OVERHEAD	17.01	0	33.12
33.13	PURCHASE DISCOUNT	B	-20,249	MENTAL HEALTH OVERHEAD	17.01	0	33.13
33.14	RENTAL	B	-26,705	PARAMED ED PGRM-RADIOLOGY	23.00	0	33.14
33.15	MISC INCOME	B	-289	SUBPROVIDER - IRF	41.00	0	33.15
33.16	MISC INCOME	B	-21,361	OPERATING ROOM	50.00	0	33.16
33.17	MISC INCOME	B	-17,985	OPERATING ROOM	50.00	0	33.17
33.18	RENTAL	B	-135	DELIVERY ROOM & LABOR ROOM	52.00	0	33.18
33.19	MISC INCOME	B	-2,674	PHYSICAL THERAPY	66.00	0	33.19
33.20	MISC INCOME	B	-9,356	ELECTROCARDIOLOGY	69.00	0	33.20
33.21	MISC INCOME	B	-1,050	ELECTROCARDIOLOGY	69.00	0	33.21
33.22	RENTAL	B	-467	DRUGS CHARGED TO PATIENTS	73.00	0	33.22
33.23	MISC INCOME	B	-209,584	INPATIENT DIALYSIS	76.01	0	33.23
33.24	RENTAL	B	-129	CLINIC	90.00	0	33.24
33.25	MISC INCOME	B	-5,625	CLINIC	90.00	0	33.25
33.26	OTHER MISC FEES	B	-654,253	DIETARY	10.00	0	33.26
33.27	PROVIDER ASSESSMENT FEE	A	-8,393,957	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	ANESTHESIOLOGY BENEIFTS	A	-419,809	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.28
33.29	GME CONSORTIUM FEES	A	-250,000	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	INTEREST INCOME	B	-688,183	CAP REL COSTS-BLDG & FIXT	1.00	11	33.30
33.31	PHYSICIAN BILLING COSTS	A	-287,575	PATIENT ACCOUNTS	4.04	0	33.31
33.32	2004 SURETY BOND EXPENSE	A	-20,524	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	DONATIONS EXPENSE	A	-58,442	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.35	PHYSICIAN EMPLOYEE BENEFIT COMPENSAT	A	-28,865	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.35
33.36	PHYSICIAN ON-CALL TIME	A	-9,376	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	ADVERTISING	A	-100	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	ADVERTISING	A	-638	SUBPROVIDER - IRF	41.00	0	33.38
33.43	ADVERTISING	A	-52	PATIENT ACCOUNTS	4.04	0	33.43
33.44	ADVERTISING	A	-52	RESPIRATORY THERAPY	65.00	0	33.44
33.46	ADVERTISING	A	-5,123	ELECTROCARDIOLOGY	69.00	0	33.46
33.47	ADVERTISING	A	-71	HOSPICE	116.00	0	33.47
33.48	ADVERTISING	A	-390	RADIOLOGY-DIAGNOSTIC	54.00	0	33.48
33.49	ADVERTISING	A	-99	PHYSICAL THERAPY	66.00	0	33.49
33.50	2012 BOND ISSUE COSTS	A	45,855	ADMINISTRATIVE & GENERAL	5.00	0	33.50
33.51	IHA LOBBYING OFFSET	A	-12,030	ADMINISTRATIVE & GENERAL	5.00	0	33.51
33.53	INDIANA CHAMBER LOBBYING OFFSET	A	-144	ADMINISTRATIVE & GENERAL	5.00	0	33.53
33.54	ALCOHOL BEVERAGES FURNISHED	A	-449	ADMINISTRATIVE & GENERAL	5.00	0	33.54
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-25,383,442				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: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2018 4:14 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	205,663	9,376	196,287	211,500	1,050	1.00
2.00	13.00	NURSING ADMINISTRATION	6,000	0	6,000	211,500	60	2.00
3.00	15.00	PHARMACY	1,529	1,529	0	211,500	0	3.00
4.00	17.01	MENTAL HEALTH OVERHEAD	657,142	615,142	42,000	211,500	120	4.00
5.00	41.00	SUBPROVIDER - IRF	97,000	0	97,000	211,500	1,588	5.00
6.00	50.00	OPERATING ROOM	2,214,758	2,214,758	0	246,400	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	312,390	312,390	0	271,900	0	7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	169,342	169,342	0	271,900	0	8.00
9.00	60.00	LABORATORY	131,976	65,581	66,395	211,500	1,427	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	211,500	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	2,028,107	1,789,834	238,273	211,500	520	11.00
12.00	70.01	NEURODIAGNOSTICS	0	0	0	211,500	0	12.00
13.00	75.00	ASC (NON-DISTINCT PART)	70,370	41,700	28,670	211,500	264	13.00
14.00	76.01	INPATIENT DIALYSIS	0	0	0	211,500	0	14.00
15.00	90.00	CLINIC	1,261,598	1,252,598	9,000	211,500	144	15.00
16.00	91.00	EMERGENCY	5,331,087	5,271,819	59,268	211,500	422	16.00
17.00	90.01	OUTPATIENT PSYCH	3,400	3,400	0	211,500	0	17.00
200.00			12,490,362	11,747,469	742,893		5,595	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	106,767	5,338	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	6,101	305	0	0	0	2.00
3.00	15.00	PHARMACY	0	0	0	0	0	3.00
4.00	17.01	MENTAL HEALTH OVERHEAD	12,202	610	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	161,472	8,074	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	145,101	7,255	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	52,875	2,644	0	0	0	11.00
12.00	70.01	NEURODIAGNOSTICS	0	0	0	0	0	12.00
13.00	75.00	ASC (NON-DISTINCT PART)	26,844	1,342	0	0	0	13.00
14.00	76.01	INPATIENT DIALYSIS	0	0	0	0	0	14.00
15.00	90.00	CLINIC	14,642	732	0	0	0	15.00
16.00	91.00	EMERGENCY	42,910	2,146	0	0	0	16.00
17.00	90.01	OUTPATIENT PSYCH	0	0	0	0	0	17.00
200.00			568,914	28,446	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	106,767	89,520	98,896		1.00
2.00	13.00	NURSING ADMINISTRATION	0	6,101	0	0		2.00
3.00	15.00	PHARMACY	0	0	0	1,529		3.00
4.00	17.01	MENTAL HEALTH OVERHEAD	0	12,202	29,798	644,940		4.00
5.00	41.00	SUBPROVIDER - IRF	0	161,472	0	0		5.00
6.00	50.00	OPERATING ROOM	0	0	0	2,214,758		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	312,390		7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	0	0	0	169,342		8.00
9.00	60.00	LABORATORY	0	145,101	0	65,581		9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	52,875	185,398	1,975,232		11.00
12.00	70.01	NEURODIAGNOSTICS	0	0	0	0		12.00
13.00	75.00	ASC (NON-DISTINCT PART)	0	26,844	1,826	43,526		13.00
14.00	76.01	INPATIENT DIALYSIS	0	0	0	0		14.00
15.00	90.00	CLINIC	0	14,642	0	1,252,598		15.00
16.00	91.00	EMERGENCY	0	42,910	16,358	5,288,177		16.00
17.00	90.01	OUTPATIENT PSYCH	0	0	0	3,400		17.00
200.00			0	568,914	322,900	12,070,369		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	22,681,243	22,681,243				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	216,351		216,351			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	29,634,913	118,861	1,097	29,754,871		4.00
4.01	00401	COMMUNICATIONS	279,962	0	0	78,614	358,576	4.01
4.02	00402	PURCHASING & RECEIVING	658,867	410,857	3,770	197,227	2,869	4.02
4.03	00403	REGISTRATION	1,220,385	0	0	333,031	3,028	4.03
4.04	00404	PATIENT ACCOUNTS	3,923,508	0	0	662,044	12,590	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	18,084,368	1,114,794	11,385	2,519,574	24,383	5.00
7.00	00700	OPERATION OF PLANT	6,042,941	3,456,129	34,285	670,008	23,586	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	390,080	139,217	1,313	57,885	0	8.00
9.00	00900	HOUSEKEEPING	2,278,343	193,942	1,829	580,797	5,897	9.00
10.00	01000	DIETARY	97,698	0	0	106,419	4,622	10.00
11.00	01100	CAFETERIA	1,850,133	330,964	3,122	314,726	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,777,292	227,093	2,142	433,448	3,028	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	538,653	2,379	22	106,125	3,028	14.00
15.00	01500	PHARMACY	3,182,842	163,618	1,543	809,526	5,100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,845,613	124,703	1,176	671,196	8,287	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	2,084,783	90,996	858	718,022	27,571	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	213,029	0	0	62,071	0	23.00
23.01	02302	PARAMED ED PGRM-LAB	216,398	0	0	62,598	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,056,203	1,846,542	17,416	1,328,278	28,367	30.00
31.00	03100	INTENSIVE CARE UNIT	3,825,711	706,845	6,667	990,893	15,140	31.00
40.00	04000	SUBPROVIDER - IPF	918,727	344,579	3,250	232,301	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,314,580	454,531	4,287	569,733	11,315	41.00
43.00	04300	NURSERY	337,431	0	0	87,512	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,056,829	499,791	4,714	1,142,207	21,993	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,210,766	323,509	3,051	272,406	3,984	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,346,080	0	0	343,920	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,885,546	872,367	8,228	1,225,856	14,662	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,721,193	203,485	1,919	367,520	5,737	55.00
60.00	06000	LABORATORY	4,883,525	191,351	1,805	662,035	5,100	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,084,228	150,135	1,416	568,762	6,056	65.00
66.00	06600	PHYSICAL THERAPY	3,641,041	583,199	5,501	997,185	4,144	66.00
69.00	06900	ELECTROCARDIOLOGY	3,199,647	480,650	4,533	1,291,057	12,590	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	474,759	202,111	1,906	92,767	3,187	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,788,391	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,812,265	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,578,268	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,914,910	0	0	344,702	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	369,257	226,882	2,140	0	478	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,810,838	70,534	665	705,860	19,124	90.00
90.01	09001	OUTPATIENT PSYCH	1,346,272	76,191	719	119,203	1,594	90.01
91.00	09100	EMERGENCY	5,012,885	458,496	4,324	1,268,659	8,765	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	114,412	10,416	98	22,671	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	818,789	104,981	990	141,047	3,665	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	176,739,955	14,180,148	136,171	21,157,885	289,890	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1,116	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,838,761	3,046,753	28,736	7,611,177	62,948	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	19,843	67,044	632	0	3,347	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	867,559	49,887	471	51,373	0	194.02
194.03	07953	MH RESIDENTIAL	420,255	535,613	5,052	104,263	956	194.03
194.04	07954	UNUSED SPACE	0	3,063,700	28,896	0	0	194.04
194.05	07955	MOB	43,407	633,006	5,970	0	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
194.06	07956	FOUNDATION	1,009,353	12,320	116	36,616	319	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	124,571	1,175	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	3,327,313	968,201	9,132	793,557	0	194.09
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)	219,266,446	22,681,243	216,351	29,754,871	358,576	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING	1,273,590					4.02
4.03	00403	REGISTRATION	324	1,556,768				4.03
4.04	00404	PATIENT ACCOUNTS	2,946	0	4,601,088			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	6,784	0	0	21,761,288	21,761,288	5.00
7.00	00700	OPERATION OF PLANT	7,956	0	0	10,234,905	1,127,692	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,004	0	0	591,499	65,172	8.00
9.00	00900	HOUSEKEEPING	7,070	0	0	3,067,878	338,022	9.00
10.00	01000	DIETARY	53,407	0	0	262,146	28,884	10.00
11.00	01100	CAFETERIA	0	0	0	2,498,945	275,336	11.00
13.00	01300	NURSING ADMINISTRATION	461	0	0	2,443,464	269,223	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,326	0	0	654,533	72,117	14.00
15.00	01500	PHARMACY	502,448	0	0	4,665,077	514,003	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	330	0	0	3,651,305	402,304	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	4,805	0	0	2,927,035	322,504	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	5	0	0	275,105	30,311	23.00
23.01	02302	PARAMED ED PGRM-LAB	106	0	0	279,102	30,752	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,915	103,672	306,365	8,699,758	958,548	30.00
31.00	03100	INTENSIVE CARE UNIT	7,843	44,212	130,654	5,727,965	631,113	31.00
40.00	04000	SUBPROVIDER - IPF	0	17,464	51,609	1,567,930	172,756	40.00
41.00	04100	SUBPROVIDER - IRF	3,166	19,520	57,683	3,434,815	378,451	41.00
43.00	04300	NURSERY	746	3,633	10,737	440,059	48,486	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,193	113,418	335,168	6,199,313	683,047	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	5,933	29,505	87,192	1,936,346	213,349	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,550	13,207	39,029	1,745,786	192,352	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,623	245,189	725,175	8,982,646	989,717	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,127	64,533	190,705	2,558,219	281,867	55.00
60.00	06000	LABORATORY	39,091	179,683	530,988	6,493,578	715,469	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	858	43,224	127,734	2,982,413	328,605	65.00
66.00	06600	PHYSICAL THERAPY	1,136	61,305	181,166	5,474,677	603,205	66.00
69.00	06900	ELECTROCARDIOLOGY	2,058	90,096	266,246	5,346,877	589,124	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	992	14,393	42,534	832,649	91,742	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	208,004	23,549	69,592	7,089,536	781,132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	242,936	44,346	131,050	6,230,597	686,493	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	199,090	588,340	14,365,698	1,582,827	73.00
75.00	07500	ASC (NON-DISTINCT PART)	13,144	55,200	163,125	2,491,081	274,470	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	48	3,188	9,421	611,414	67,366	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,568	3,620	10,697	2,622,906	288,994	90.00
90.01	09001	OUTPATIENT PSYCH	3,133	19,298	57,028	1,623,438	178,872	90.01
91.00	09100	EMERGENCY	8,549	150,792	445,612	7,358,082	810,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,214	1,549	4,577	154,937	17,071	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	530	13,082	38,661	1,121,745	123,595	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,185,329	1,556,768	4,601,088	159,404,747	15,165,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,116	123	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	71,778	0	0	47,660,153	5,251,217	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	143	0	0	91,009	10,027	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	12,870	0	0	982,160	108,215	194.02
194.03	07953	MH RESIDENTIAL	1,348	0	0	1,067,487	117,617	194.03
194.04	07954	UNUSED SPACE	0	0	0	3,092,596	340,745	194.04
194.05	07955	MOB	0	0	0	682,383	75,186	194.05
194.06	07956	FOUNDATION	2,072	0	0	1,060,796	116,880	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	125,746	13,855	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	50	0	0	5,098,253	561,731	194.09
200.00		Cross Foot Adjustments				0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
		4.02	4.03	4.04	4A.04	5.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,273,590	1,556,768	4,601,088	219,266,446	21,761,288	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	11,362,597					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	89,978	746,649				8.00
9.00	00900	HOUSEKEEPING	125,347	40,961	3,572,208			9.00
10.00	01000	DIETARY	0	15,896	69,434	376,360		10.00
11.00	01100	CAFETERIA	213,907	0	51,985	0	3,040,173	11.00
13.00	01300	NURSING ADMINISTRATION	146,774	0	0	0	44,968	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,538	3,777	59,264	0	28,985	14.00
15.00	01500	PHARMACY	105,749	0	33,401	0	84,580	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	80,597	0	40,731	0	131,489	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	58,812	11,070	141,552	0	115,348	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	0	0	0	7,593	23.00
23.01	02302	PARAMED ED PGRM-LAB	0	0	0	0	7,862	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,193,447	261,759	881,786	153,206	254,188	30.00
31.00	03100	INTENSIVE CARE UNIT	456,844	80,759	285,841	80,323	166,747	31.00
40.00	04000	SUBPROVIDER - IPF	222,707	0	0	48,132	37,125	40.00
41.00	04100	SUBPROVIDER - IRF	293,770	45,339	167,519	83,642	99,069	41.00
43.00	04300	NURSERY	0	4,370	10,170	11,057	12,449	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	323,022	28,234	342,575	0	91,451	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	209,089	16,374	52,708	0	39,443	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,989	11,512	0	53,798	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	563,823	60,552	174,075	0	169,935	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	131,515	0	0	0	48,287	55.00
60.00	06000	LABORATORY	123,673	0	45,119	0	128,402	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	97,035	74	42,590	0	79,989	65.00
66.00	06600	PHYSICAL THERAPY	376,930	10,084	101,131	0	141,531	66.00
69.00	06900	ELECTROCARDIOLOGY	310,651	13,170	109,700	0	113,579	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	130,627	10,313	42,228	0	16,141	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	25,571	122,555	0	56,675	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	146,637	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	45,587	245	29,787	0	67,685	90.00
90.01	09001	OUTPATIENT PSYCH	49,244	18,212	14,506	0	14,644	90.01
91.00	09100	EMERGENCY	296,333	72,485	171,081	0	210,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	6,732	0	0	0	4,185	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	67,851	0	34,949	0	23,540	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,868,219	725,234	3,036,199	376,360	2,250,567	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,969,161	21,415	505,964	0	620,032	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	43,332	0	21,166	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	32,242	0	8,879	0	8,829	194.02
194.03	07953	MH RESIDENTIAL	346,174	0	0	0	29,765	194.03
194.04	07954	UNUSED SPACE	1,980,112	0	0	0	0	194.04
194.05	07955	MOB	409,121	0	0	0	0	194.05
194.06	07956	FOUNDATION	7,962	0	0	0	4,955	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	80,512	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	625,762	0	0	0	126,025	194.09
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	11,362,597	746,649	3,572,208	376,360	3,040,173	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,904,429					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	820,214				14.00
15.00	01500	PHARMACY	0	347,104	5,749,914			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	228	0	4,306,654		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	0	3,320	559	0	0	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	3	0	0	0	23.00
23.01	02302	PARAMED ED PGRM-LAB	0	73	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	777,745	8,922	6,195	508,773	0	30.00
31.00	03100	INTENSIVE CARE UNIT	510,198	5,418	4,000	523,104	0	31.00
40.00	04000	SUBPROVIDER - IPF	113,591	0	0	93,156	0	40.00
41.00	04100	SUBPROVIDER - IRF	303,125	2,187	2,383	193,477	0	41.00
43.00	04300	NURSERY	38,091	515	52	50,161	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	279,815	17,403	28,459	114,653	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	4,099	1,022	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	164,608	2,452	911	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,884	47,240	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	2,160	901	0	0	55.00
60.00	06000	LABORATORY	0	27,005	1,084	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	593	728	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	785	1,379	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,422	25,190	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	685	6	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	143,691	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	167,823	4,936,071	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	9,080	15,608	781,074	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	33	1,844	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,083	180,094	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0	2,164	7,508	121,819	0	90.01
91.00	09100	EMERGENCY	645,230	5,905	7,065	1,920,437	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	839	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	72,026	0	7	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,904,429	758,876	5,268,306	4,306,654	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	366	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	49,585	481,487	0	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	99	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	8,891	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	931	121	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	1,431	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	35	0	0	0	194.09

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,904,429	820,214	5,749,914	4,306,654	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	MENTAL HEALTH OVERHEAD	PARAMED ED PGRM-RADIOLOGY	PARAMED ED PGRM-LAB	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.01	23.00	23.01	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OVERHEAD	3,580,200					17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	313,012				23.00
23.01	02302	PARAMED ED PGRM-LAB	0		317,789			23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,387,352	0	0	15,091,679	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	8,472,312	0	31.00
40.00	04000	SUBPROVIDER - IPF	408,518	0	0	2,663,915	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	5,003,777	0	41.00
43.00	04300	NURSERY	0	0	0	615,410	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	8,107,972	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	2,472,430	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,177,408	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	313,012	0	11,304,884	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	3,022,949	0	55.00
60.00	06000	LABORATORY	0	0	317,789	7,852,119	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,532,027	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,709,722	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,509,713	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	1,124,391	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,870,668	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,060,781	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,052,419	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,291,227	0	0	5,067,341	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	827,294	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	3,236,381	0	90.00
90.01	09001	OUTPATIENT PSYCH	0	0	0	2,030,407	0	90.01
91.00	09100	EMERGENCY	0	0	0	11,498,218	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	183,764	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	1,443,713	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,087,097	313,012	317,789	144,931,694	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,605	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	56,559,014	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	165,633	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	1,149,216	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	1,562,095	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	5,413,453	0	194.04
194.05	07955	MOB	0	0	0	1,166,690	0	194.05
194.06	07956	FOUNDATION	0	0	0	1,192,024	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	220,113	0	194.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	MENTAL HEALTH OVERHEAD	PARAMED ED PGRM-RADIOLOGY	PARAMED ED PGRM-LAB	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.01	23.00	23.01	24.00	25.00	
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	493,103	0	0	6,904,909	0	194.09
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,580,200	313,012	317,789	219,266,446	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
4.01	00401	COMMUNICATIONS			4.01
4.02	00402	PURCHASING & RECEIVING			4.02
4.03	00403	REGISTRATION			4.03
4.04	00404	PATIENT ACCOUNTS			4.04
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
17.01	01701	MENTAL HEALTH OVERHEAD			17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY			23.00
23.01	02302	PARAMED ED PGRM-LAB			23.01
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	15,091,679		30.00
31.00	03100	INTENSIVE CARE UNIT	8,472,312		31.00
40.00	04000	SUBPROVIDER - IPF	2,663,915		40.00
41.00	04100	SUBPROVIDER - IRF	5,003,777		41.00
43.00	04300	NURSERY	615,410		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	8,107,972		50.00
51.00	05100	RECOVERY ROOM	0		51.00
51.01	05101	ENDOSCOPY	2,472,430		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,177,408		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,304,884		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,022,949		55.00
60.00	06000	LABORATORY	7,852,119		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
65.00	06500	RESPIRATORY THERAPY	3,532,027		65.00
66.00	06600	PHYSICAL THERAPY	6,709,722		66.00
69.00	06900	ELECTROCARDIOLOGY	6,509,713		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
70.01	07001	NEURODIAGNOSTICS	1,124,391		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,870,668		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,060,781		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,052,419		73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,067,341		75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0		76.00
76.01	03950	INPATIENT DIALYSIS	827,294		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	3,236,381		90.00
90.01	09001	OUTPATIENT PSYCH	2,030,407		90.01
91.00	09100	EMERGENCY	11,498,218		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	183,764		96.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	1,443,713		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,931,694		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,605		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,559,014		192.00
194.00	07950	COMMUNITY HEALTH SERVICES	165,633		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,149,216		194.02
194.03	07953	MH RESIDENTIAL	1,562,095		194.03
194.04	07954	UNUSED SPACE	5,413,453		194.04
194.05	07955	MOB	1,166,690		194.05
194.06	07956	FOUNDATION	1,192,024		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	220,113		194.07
194.08	07958	INDUSTRIAL HEALTH	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	6,904,909		194.09
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00

COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-0042	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	Total		
		26.00		
202.00	TOTAL (sum lines 118 through 201)	219,266,446		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	118,861	1,097	119,958	119,958	4.00
4.01	00401	COMMUNICATIONS	0	0	0	0	317	4.01
4.02	00402	PURCHASING & RECEIVING	0	410,857	3,770	414,627	795	4.02
4.03	00403	REGISTRATION	0	0	0	0	1,342	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	0	0	2,668	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,114,794	11,385	1,126,179	10,156	5.00
7.00	00700	OPERATION OF PLANT	0	3,456,129	34,285	3,490,414	2,701	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	139,217	1,313	140,530	233	8.00
9.00	00900	HOUSEKEEPING	0	193,942	1,829	195,771	2,341	9.00
10.00	01000	DIETARY	0	0	0	0	429	10.00
11.00	01100	CAFETERIA	0	330,964	3,122	334,086	1,269	11.00
13.00	01300	NURSING ADMINISTRATION	0	227,093	2,142	229,235	1,747	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,379	22	2,401	428	14.00
15.00	01500	PHARMACY	0	163,618	1,543	165,161	3,263	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	124,703	1,176	125,879	2,705	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	0	90,996	858	91,854	2,894	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	0	0	0	250	23.00
23.01	02302	PARAMED ED PGRM-LAB	0	0	0	0	252	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,846,542	17,416	1,863,958	5,354	30.00
31.00	03100	INTENSIVE CARE UNIT	0	706,845	6,667	713,512	3,994	31.00
40.00	04000	SUBPROVIDER - IPF	0	344,579	3,250	347,829	936	40.00
41.00	04100	SUBPROVIDER - IRF	0	454,531	4,287	458,818	2,296	41.00
43.00	04300	NURSERY	0	0	0	0	353	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	499,791	4,714	504,505	4,604	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	323,509	3,051	326,560	1,098	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	1,386	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	872,367	8,228	880,595	4,941	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	203,485	1,919	205,404	1,481	55.00
60.00	06000	LABORATORY	0	191,351	1,805	193,156	2,668	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	150,135	1,416	151,551	2,292	65.00
66.00	06600	PHYSICAL THERAPY	0	583,199	5,501	588,700	4,019	66.00
69.00	06900	ELECTROCARDIOLOGY	0	480,650	4,533	485,183	5,204	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	202,111	1,906	204,017	374	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	1,389	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	226,882	2,140	229,022	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	70,534	665	71,199	2,845	90.00
90.01	09001	OUTPATIENT PSYCH	0	76,191	719	76,910	480	90.01
91.00	09100	EMERGENCY	0	458,496	4,324	462,820	5,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	10,416	98	10,514	91	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	104,981	990	105,971	569	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14,180,148	136,171	14,316,319	85,278	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,046,753	28,736	3,075,489	30,706	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	67,044	632	67,676	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	49,887	471	50,358	207	194.02
194.03	07953	MH RESIDENTIAL	0	535,613	5,052	540,665	420	194.03
194.04	07954	UNUSED SPACE	0	3,063,700	28,896	3,092,596	0	194.04
194.05	07955	MOB	0	633,006	5,970	638,976	0	194.05
194.06	07956	FOUNDATION	0	12,320	116	12,436	148	194.06

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
194.07	07957	KNOX COUNTY HEALTH DEPT	0	124,571	1,175	125,746	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	968,201	9,132	977,333	3,199	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	22,681,243	216,351	22,897,594	119,958	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	317					4.01
4.02	00402	PURCHASING & RECEIVING	3	415,425				4.02
4.03	00403	REGISTRATION	3	106	1,451			4.03
4.04	00404	PATIENT ACCOUNTS	11	961	0	3,640		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	22	2,213	0	0	1,138,570	5.00
7.00	00700	OPERATION OF PLANT	21	2,595	0	0	59,004	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	980	0	0	3,410	8.00
9.00	00900	HOUSEKEEPING	5	2,306	0	0	17,686	9.00
10.00	01000	DIETARY	4	17,420	0	0	1,511	10.00
11.00	01100	CAFETERIA	0	0	0	0	14,406	11.00
13.00	01300	NURSING ADMINISTRATION	3	150	0	0	14,087	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3	1,411	0	0	3,773	14.00
15.00	01500	PHARMACY	5	163,893	0	0	26,894	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7	108	0	0	21,050	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	24	1,567	0	0	16,874	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	2	0	0	1,586	23.00
23.01	02302	PARAMED ED PGRM-LAB	0	35	0	0	1,609	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25	4,213	113	227	50,154	30.00
31.00	03100	INTENSIVE CARE UNIT	13	2,558	48	97	33,022	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	19	38	9,039	40.00
41.00	04100	SUBPROVIDER - IRF	10	1,033	21	43	19,802	41.00
43.00	04300	NURSERY	0	243	4	8	2,537	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19	8,217	124	248	35,739	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	4	1,935	32	65	11,163	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,158	14	29	10,064	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13	1,834	17	769	51,785	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	5	1,020	71	141	14,748	55.00
60.00	06000	LABORATORY	5	12,751	197	393	37,435	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5	280	47	95	17,194	65.00
66.00	06600	PHYSICAL THERAPY	4	371	67	134	31,562	66.00
69.00	06900	ELECTROCARDIOLOGY	11	671	99	197	30,825	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	3	323	16	31	4,800	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	67,847	26	52	40,871	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	79,241	49	97	35,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	218	436	82,818	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	4,287	60	121	14,361	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	16	3	7	3,525	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	17	511	4	8	15,121	90.00
90.01	09001	OUTPATIENT PSYCH	1	1,022	21	42	9,359	90.01
91.00	09100	EMERGENCY	8	2,788	165	330	42,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	396	2	3	893	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3	173	14	29	6,467	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	257	386,635	1,451	3,640	793,512	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0	0	0	6	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55	23,413	0	0	274,717	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	3	47	0	0	525	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	4,198	0	0	5,662	194.02
194.03	07953	MH RESIDENTIAL	1	440	0	0	6,154	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	17,829	194.04
194.05	07955	MOB	0	0	0	0	3,934	194.05
194.06	07956	FOUNDATION	0	676	0	0	6,115	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	725	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	16	0	0	29,391	194.09
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
		4.01	4.02	4.03	4.04	5.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	317	415,425	1,451	3,640	1,138,570	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	3,554,735					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,149	173,302				8.00
9.00	00900	HOUSEKEEPING	39,214	9,507	266,830			9.00
10.00	01000	DIETARY	0	3,690	5,186	28,240		10.00
11.00	01100	CAFETERIA	66,920	0	3,883	0	420,564	11.00
13.00	01300	NURSING ADMINISTRATION	45,917	0	0	0	6,221	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	481	877	4,427	0	4,010	14.00
15.00	01500	PHARMACY	33,083	0	2,495	0	11,700	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,215	0	3,042	0	18,190	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	18,399	2,569	10,573	0	15,957	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	0	0	0	1,050	23.00
23.01	02302	PARAMED ED PGRM-LAB	0	0	0	0	1,088	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	373,364	60,756	65,867	11,495	35,163	30.00
31.00	03100	INTENSIVE CARE UNIT	142,922	18,745	21,351	6,027	23,067	31.00
40.00	04000	SUBPROVIDER - IPF	69,673	0	0	3,612	5,136	40.00
41.00	04100	SUBPROVIDER - IRF	91,904	10,523	12,513	6,276	13,705	41.00
43.00	04300	NURSERY	0	1,014	760	830	1,722	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	101,056	6,553	25,589	0	12,651	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	65,412	3,800	3,937	0	5,456	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,390	860	0	7,442	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	176,389	14,055	13,003	0	23,508	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	41,144	0	0	0	6,680	55.00
60.00	06000	LABORATORY	38,690	0	3,370	0	17,763	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	30,357	17	3,181	0	11,065	65.00
66.00	06600	PHYSICAL THERAPY	117,921	2,341	7,554	0	19,579	66.00
69.00	06900	ELECTROCARDIOLOGY	97,186	3,057	8,194	0	15,712	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	40,866	2,394	3,154	0	2,233	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	5,935	9,154	0	7,840	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	45,875	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,262	57	2,225	0	9,363	90.00
90.01	09001	OUTPATIENT PSYCH	15,406	4,227	1,084	0	2,026	90.01
91.00	09100	EMERGENCY	92,706	16,824	12,779	0	29,172	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,106	0	0	0	579	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	21,227	0	2,611	0	3,256	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,835,844	168,331	226,792	28,240	311,334	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	616,043	4,971	37,794	0	85,772	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	13,556	0	1,581	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	10,087	0	663	0	1,221	194.02
194.03	07953	MH RESIDENTIAL	108,299	0	0	0	4,118	194.03
194.04	07954	UNUSED SPACE	619,468	0	0	0	0	194.04
194.05	07955	MOB	127,992	0	0	0	0	194.05
194.06	07956	FOUNDATION	2,491	0	0	0	685	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	25,188	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	195,767	0	0	0	17,434	194.09
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3,554,735	173,302	266,830	28,240	420,564	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	297,360					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,811				14.00
15.00	01500	PHARMACY	0	7,534	414,028			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5	0	196,201		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	0	72	40	0	0	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02302	PARAMED ED PGRM-LAB	0	2	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	79,626	194	446	23,178	0	30.00
31.00	03100	INTENSIVE CARE UNIT	52,235	118	288	23,831	0	31.00
40.00	04000	SUBPROVIDER - IPF	11,630	0	0	4,244	0	40.00
41.00	04100	SUBPROVIDER - IRF	31,034	48	172	8,814	0	41.00
43.00	04300	NURSERY	3,900	11	4	2,285	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,648	378	2,049	5,223	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	89	74	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,853	53	66	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84	3,402	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	47	65	0	0	55.00
60.00	06000	LABORATORY	0	587	78	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	13	52	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17	99	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	31	1,814	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	15	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,121	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,645	355,425	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	197	1,124	35,584	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	1	133	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	24	12,968	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0	47	541	5,550	0	90.01
91.00	09100	EMERGENCY	66,060	128	509	87,492	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	18	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	7,374	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,360	16,479	379,349	196,201	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,077	34,670	0	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	2	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	193	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	20	9	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	31	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	1	0	0	0	194.09

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	297,360	17,811	414,028	196,201	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	MENTAL HEALTH OVERHEAD	PARAMED ED PGRM-RADIOLOGY	PARAMED ED PGRM-LAB	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.01	23.00	23.01	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OVERHEAD	160,823					17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	2,888				23.00
23.01	02302	PARAMED ED PGRM-LAB	0		2,986			23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,325			2,636,458	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0			1,041,828	0	31.00
40.00	04000	SUBPROVIDER - IPF	18,350			470,506	0	40.00
41.00	04100	SUBPROVIDER - IRF	0			657,012	0	41.00
43.00	04300	NURSERY	0			13,671	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0			735,603	0	50.00
51.00	05100	RECOVERY ROOM	0			0	0	51.00
51.01	05101	ENDOSCOPY	0			419,625	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0			39,315	0	52.00
53.00	05300	ANESTHESIOLOGY	0			0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0			1,170,395	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0			270,806	0	55.00
60.00	06000	LABORATORY	0			307,093	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0			0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0			216,149	0	65.00
66.00	06600	PHYSICAL THERAPY	0			772,368	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0			648,184	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0			0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0			258,226	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0			108,796	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0			118,427	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0			442,542	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	57,999			138,051	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0			0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0			278,582	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0			128,604	0	90.00
90.01	09001	OUTPATIENT PSYCH	0			116,716	0	90.01
91.00	09100	EMERGENCY	0			819,314	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0			14,602	0	96.00
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			147,694	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,674	0	0	11,970,567	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			15	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0			4,184,707	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0			83,390	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0			72,589	0	194.02
194.03	07953	MH RESIDENTIAL	0			660,126	0	194.03
194.04	07954	UNUSED SPACE	0			3,729,893	0	194.04
194.05	07955	MOB	0			770,902	0	194.05
194.06	07956	FOUNDATION	0			22,582	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0			151,659	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	MENTAL HEALTH OVERHEAD	PARAMED ED PGRM-RADIOLOGY	PARAMED ED PGRM-LAB	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.01	23.00	23.01	24.00	25.00	
194.08	07958	INDUSTRIAL HEALTH	0			0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	22,149			1,245,290	0	194.09
200.00		Cross Foot Adjustments		2,888	2,986	5,874	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	160,823	2,888	2,986	22,897,594	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
4.01	00401	COMMUNICATIONS			4.01
4.02	00402	PURCHASING & RECEIVING			4.02
4.03	00403	REGISTRATION			4.03
4.04	00404	PATIENT ACCOUNTS			4.04
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
17.01	01701	MENTAL HEALTH OVERHEAD			17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY			23.00
23.01	02302	PARAMED ED PGRM-LAB			23.01
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,636,458		30.00
31.00	03100	INTENSIVE CARE UNIT	1,041,828		31.00
40.00	04000	SUBPROVIDER - IPF	470,506		40.00
41.00	04100	SUBPROVIDER - IRF	657,012		41.00
43.00	04300	NURSERY	13,671		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	735,603		50.00
51.00	05100	RECOVERY ROOM	0		51.00
51.01	05101	ENDOSCOPY	419,625		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,315		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,170,395		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	270,806		55.00
60.00	06000	LABORATORY	307,093		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
65.00	06500	RESPIRATORY THERAPY	216,149		65.00
66.00	06600	PHYSICAL THERAPY	772,368		66.00
69.00	06900	ELECTROCARDIOLOGY	648,184		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
70.01	07001	NEURODIAGNOSTICS	258,226		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108,796		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,427		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	442,542		73.00
75.00	07500	ASC (NON-DISTINCT PART)	138,051		75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0		76.00
76.01	03950	INPATIENT DIALYSIS	278,582		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	128,604		90.00
90.01	09001	OUTPATIENT PSYCH	116,716		90.01
91.00	09100	EMERGENCY	819,314		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,602		96.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	147,694		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,970,567		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,184,707		192.00
194.00	07950	COMMUNITY HEALTH SERVICES	83,390		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	72,589		194.02
194.03	07953	MH RESIDENTIAL	660,126		194.03
194.04	07954	UNUSED SPACE	3,729,893		194.04
194.05	07955	MOB	770,902		194.05
194.06	07956	FOUNDATION	22,582		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	151,659		194.07
194.08	07958	INDUSTRIAL HEALTH	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	1,245,290		194.09
200.00		Cross Foot Adjustments	5,874		200.00
201.00		Negative Cost Centers	0		201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	Total		
		26.00		
202.00	TOTAL (sum lines 118 through 201)	22,897,594		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			1.00	2.00	4.00	4.01	4.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	857,937					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		867,686				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,496	4,401	105,573,416			4.00
4.01	00401	COMMUNICATIONS	0	0	278,932	2,250		4.01
4.02	00402	PURCHASING & RECEIVING	15,541	15,121	699,780	18	35,587,987	4.02
4.03	00403	REGISTRATION	0	0	1,181,628	19	9,046	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	2,348,997	79	82,317	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	42,168	45,660	8,939,701	153	189,575	5.00
7.00	00700	OPERATION OF PLANT	130,731	137,503	2,377,257	148	222,302	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,266	5,266	205,383	0	83,929	8.00
9.00	00900	HOUSEKEEPING	7,336	7,336	2,060,725	37	197,562	9.00
10.00	01000	DIETARY	0	0	377,585	29	1,492,353	10.00
11.00	01100	CAFETERIA	12,519	12,519	1,116,678	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,590	8,590	1,537,918	19	12,882	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90	90	376,541	19	120,872	14.00
15.00	01500	PHARMACY	6,189	6,189	2,872,278	32	14,039,875	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,717	4,717	2,381,472	52	9,224	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	3,442	3,442	2,547,613	173	134,279	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	0	220,235	0	135	23.00
23.01	02302	PARAMED ED PGRM-LAB	0	0	222,104	0	2,962	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,847	69,847	4,712,862	178	360,888	30.00
31.00	03100	INTENSIVE CARE UNIT	26,737	26,737	3,515,788	95	219,147	31.00
40.00	04000	SUBPROVIDER - IPF	13,034	13,034	824,228	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	17,193	17,193	2,021,470	71	88,467	41.00
43.00	04300	NURSERY	0	0	310,502	0	20,851	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,905	18,905	4,052,665	138	703,967	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	12,237	12,237	966,523	25	165,799	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,220,261	0	99,198	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,998	32,998	4,349,460	92	157,117	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	7,697	7,697	1,303,998	36	87,388	55.00
60.00	06000	LABORATORY	7,238	7,238	2,348,968	32	1,092,337	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,679	5,679	2,018,023	38	23,983	65.00
66.00	06600	PHYSICAL THERAPY	22,060	22,060	3,538,111	26	31,747	66.00
69.00	06900	ELECTROCARDIOLOGY	18,181	18,181	4,580,798	79	57,520	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	7,645	7,645	329,145	20	27,707	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	5,812,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,788,391	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	1,223,037	0	367,278	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	8,582	8,582	0	3	1,353	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,668	2,668	2,504,462	120	43,801	90.00
90.01	09001	OUTPATIENT PSYCH	2,882	2,882	422,943	10	87,551	90.01
91.00	09100	EMERGENCY	17,343	17,343	4,501,327	55	238,875	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	394	394	80,438	0	33,932	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,971	3,971	500,449	23	14,812	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	536,376	546,125	75,070,285	1,819	33,121,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	115,246	115,246	27,005,384	395	2,005,703	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	2,536	2,536	0	21	4,001	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,887	1,887	182,275	0	359,635	194.02
194.03	07953	MH RESIDENTIAL	20,260	20,260	369,936	6	37,664	194.03
194.04	07954	UNUSED SPACE	115,887	115,887	0	0	0	194.04
194.05	07955	MOB	23,944	23,944	0	0	0	194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			1.00	2.00	4.00	4.01	4.02	
194.06	07956	FOUNDATION	466	466	129,918	2	57,888	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	4,712	4,712	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	36,623	36,623	2,815,618	0	1,409	194.09
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)	22,681,243	216,351	29,754,871	358,576	1,273,590	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.436956	0.249343	0.281841	159.367111	0.035787	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			119,958	317	415,425	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001136	0.140889	0.011673	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION	567,844,121					4.03
4.04	00404	PATIENT ACCOUNTS	0	567,844,121				4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	-21,761,288	197,505,158		5.00
7.00	00700	OPERATION OF PLANT	0	0	0	10,234,905	665,001	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	591,499	5,266	8.00
9.00	00900	HOUSEKEEPING	0	0	0	3,067,878	7,336	9.00
10.00	01000	DIETARY	0	0	0	262,146	0	10.00
11.00	01100	CAFETERIA	0	0	0	2,498,945	12,519	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,443,464	8,590	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	654,533	90	14.00
15.00	01500	PHARMACY	0	0	0	4,665,077	6,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,651,305	4,717	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	0	0	0	2,927,035	3,442	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	0	0	275,105	0	23.00
23.01	02302	PARAMED ED PGRM-LAB	0	0	0	279,102	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,808,832	37,808,832	0	8,699,758	69,847	30.00
31.00	03100	INTENSIVE CARE UNIT	16,124,128	16,124,128	0	5,727,965	26,737	31.00
40.00	04000	SUBPROVIDER - IPF	6,369,165	6,369,165	0	1,567,930	13,034	40.00
41.00	04100	SUBPROVIDER - IRF	7,118,731	7,118,731	0	3,434,815	17,193	41.00
43.00	04300	NURSERY	1,325,119	1,325,119	0	440,059	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,363,407	41,363,407	0	6,199,313	18,905	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	10,760,512	10,760,512	0	1,936,346	12,237	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,816,626	4,816,626	0	1,745,786	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,513,537	89,513,537	0	8,982,646	32,998	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	23,535,052	23,535,052	0	2,558,219	7,697	55.00
60.00	06000	LABORATORY	65,529,838	65,529,838	0	6,493,578	7,238	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	15,763,798	15,763,798	0	2,982,413	5,679	65.00
66.00	06600	PHYSICAL THERAPY	22,357,884	22,357,884	0	5,474,677	22,060	66.00
69.00	06900	ELECTROCARDIOLOGY	32,857,700	32,857,700	0	5,346,877	18,181	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	5,249,197	5,249,197	0	832,649	7,645	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,588,405	8,588,405	0	7,089,536	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,173,022	16,173,022	0	6,230,597	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,607,654	72,607,654	0	14,365,698	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	20,131,383	20,131,383	0	2,491,081	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	1,162,694	1,162,694	0	611,414	8,582	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,320,114	1,320,114	0	2,622,906	2,668	90.00
90.01	09001	OUTPATIENT PSYCH	7,037,854	7,037,854	0	1,623,438	2,882	90.01
91.00	09100	EMERGENCY	54,993,473	54,993,473	0	7,358,082	17,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	564,850	564,850	0	154,937	394	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,771,146	4,771,146	0	1,121,745	3,971	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	567,844,121	567,844,121	-21,761,288	137,643,459	343,440	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,116	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	47,660,153	115,246	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	91,009	2,536	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	982,160	1,887	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	1,067,487	20,260	194.03
194.04	07954	UNUSED SPACE	0	0	0	3,092,596	115,887	194.04
194.05	07955	MOB	0	0	0	682,383	23,944	194.05
194.06	07956	FOUNDATION	0	0	0	1,060,796	466	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	125,746	4,712	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	5,098,253	36,623	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,556,768	4,601,088		21,761,288	11,362,597	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002742	0.008103		0.110181	17.086586	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,451	3,640		1,138,570	3,554,735	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000003	0.000006		0.005765	5.345458	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,088,971					8.00
9.00	00900	HOUSEKEEPING	59,741	69,197				9.00
10.00	01000	DIETARY	23,184	1,345	34,139			10.00
11.00	01100	CAFETERIA	0	1,007	0	2,498,499		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	36,956	780,117	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,508	1,148	0	23,821	0	14.00
15.00	01500	PHARMACY	0	647	0	69,510	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	789	0	108,061	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	16,145	2,742	0	94,796	0	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	0	0	6,240	0	23.00
23.01	02302	PARAMED ED PGRM-LAB	0	0	0	6,461	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	381,769	17,081	13,897	208,899	208,899	30.00
31.00	03100	INTENSIVE CARE UNIT	117,785	5,537	7,286	137,037	137,037	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,366	30,510	30,510	40.00
41.00	04100	SUBPROVIDER - IRF	66,126	3,245	7,587	81,418	81,418	41.00
43.00	04300	NURSERY	6,373	197	1,003	10,231	10,231	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,179	6,636	0	75,157	75,157	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	23,881	1,021	0	32,415	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,735	223	0	44,213	44,213	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,314	3,372	0	139,657	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	39,684	0	55.00
60.00	06000	LABORATORY	0	874	0	105,524	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	108	825	0	65,737	0	65.00
66.00	06600	PHYSICAL THERAPY	14,708	1,959	0	116,314	0	66.00
69.00	06900	ELECTROCARDIOLOGY	19,208	2,125	0	93,342	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	15,041	818	0	13,265	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	37,295	2,374	0	46,577	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	358	577	0	55,625	0	90.00
90.01	09001	OUTPATIENT PSYCH	26,562	281	0	12,035	0	90.01
91.00	09100	EMERGENCY	105,718	3,314	0	173,306	173,306	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	3,439	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	677	0	19,346	19,346	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,057,738	58,814	34,139	1,849,576	780,117	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,233	9,801	0	509,562	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	410	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	172	0	7,256	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	24,462	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	4,072	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	103,571	0	194.09
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)	746,649	3,572,208	376,360	3,040,173	2,904,429	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.685646	51.623741	11.024342	1.216800	3.723068	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	173,302	266,830	28,240	420,564	297,360	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.159143	3.856092	0.827206	0.168327	0.381174	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	MENTAL HEALTH OVERHEAD (CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,177,149					14.00
15.00	01500	PHARMACY	14,039,875	14,171,928				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,224	0	601			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
17.01	01701	MENTAL HEALTH OVERHEAD	134,279	1,379	0	0	55,818,843	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	135	0	0	0	0	23.00
23.01	02302	PARAMED ED PGRM-LAB	2,962	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	360,888	15,268	71	0	21,630,376	30.00
31.00	03100	INTENSIVE CARE UNIT	219,147	9,860	73	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	13	0	6,369,165	40.00
41.00	04100	SUBPROVIDER - IRF	88,467	5,874	27	0	0	41.00
43.00	04300	NURSERY	20,851	129	7	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	703,967	70,143	16	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	165,799	2,518	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,198	2,245	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,117	116,433	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	87,388	2,220	0	0	0	55.00
60.00	06000	LABORATORY	1,092,337	2,671	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	23,983	1,794	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	31,747	3,400	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	57,520	62,087	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	27,707	14	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,812,265	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,788,391	12,166,035	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	367,278	38,469	109	0	20,131,382	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	1,353	4,545	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	43,801	443,882	0	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	87,551	18,505	17	0	0	90.01
91.00	09100	EMERGENCY	238,875	17,412	268	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	33,932	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	17	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,696,037	12,984,900	601	0	48,130,923	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,812	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,005,703	1,186,730	0	0	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	4,001	0	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	359,635	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	37,664	298	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	57,888	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	MENTAL HEALTH OVERHEAD (CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	1,409	0	0	0	7,687,920	194.09
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)	820,214	5,749,914	4,306,654	0	3,580,200	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.024722	0.405726	7,165.813644	0.000000	0.064140	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,811	414,028	196,201	0	160,823	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000537	0.029215	326.457571	0.000000	0.002881	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	PARAMED ED PGRM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PGRM-LAB (ASSIGNED TIME)		
			23.00	23.01		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
4.01	00401	COMMUNICATIONS				4.01
4.02	00402	PURCHASING & RECEIVING				4.02
4.03	00403	REGISTRATION				4.03
4.04	00404	PATIENT ACCOUNTS				4.04
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	MENTAL HEALTH OVERHEAD				17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	100			23.00
23.01	02302	PARAMED ED PGRM-LAB		100		23.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	100		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03950	INPATIENT DIALYSIS	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT PSYCH	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	0		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0		194.02
194.03	07953	MH RESIDENTIAL	0	0		194.03
194.04	07954	UNUSED SPACE	0	0		194.04
194.05	07955	MOB	0	0		194.05
194.06	07956	FOUNDATION	0	0		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0		194.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:14 pm

		Cost Center Description	PARAMED ED PGRM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PGRM-LAB (ASSIGNED TIME)					
			23.00	23.01					
194.08	07958	INDUSTRIAL HEALTH	0	0					194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0					194.09
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)	313,012	317,789					202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,130.120000	3,177.890000					203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,888	2,986					204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	28.880000	29.860000					205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	0.000000					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:14 pm

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		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	15,091,679		15,091,679	0	15,091,679	30.00
31.00	03100	INTENSIVE CARE UNIT	8,472,312		8,472,312	0	8,472,312	31.00
40.00	04000	SUBPROVIDER - IPF	2,663,915		2,663,915	0	2,663,915	40.00
41.00	04100	SUBPROVIDER - IRF	5,003,777		5,003,777	0	5,003,777	41.00
43.00	04300	NURSERY	615,410		615,410	0	615,410	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,107,972		8,107,972	0	8,107,972	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	2,472,430		2,472,430	0	2,472,430	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,177,408		2,177,408	0	2,177,408	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,304,884		11,304,884	0	11,304,884	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,022,949		3,022,949	0	3,022,949	55.00
60.00	06000	LABORATORY	7,852,119		7,852,119	0	7,852,119	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,532,027	0	3,532,027	0	3,532,027	65.00
66.00	06600	PHYSICAL THERAPY	6,709,722	0	6,709,722	0	6,709,722	66.00
69.00	06900	ELECTROCARDIOLOGY	6,509,713		6,509,713	185,398	6,695,111	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,124,391		1,124,391	0	1,124,391	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,870,668		7,870,668	0	7,870,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,060,781		7,060,781	0	7,060,781	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,052,419		21,052,419	0	21,052,419	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,067,341		5,067,341	1,826	5,069,167	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	827,294		827,294	0	827,294	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,236,381		3,236,381	0	3,236,381	90.00
90.01	09001	OUTPATIENT PSYCH	2,030,407		2,030,407	0	2,030,407	90.01
91.00	09100	EMERGENCY	11,498,218		11,498,218	16,358	11,514,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,051,184		4,051,184		4,051,184	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	183,764		183,764	0	183,764	96.00
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	1,443,713		1,443,713		1,443,713	116.00
200.00		Subtotal (see instructions)	148,982,878	0	148,982,878	203,582	149,186,460	200.00
201.00		Less Observation Beds	4,051,184		4,051,184		4,051,184	201.00
202.00		Total (see instructions)	144,931,694	0	144,931,694	203,582	145,135,276	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:14 pm

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		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	21,630,376		21,630,376			30.00
31.00	03100	INTENSIVE CARE UNIT	16,124,128		16,124,128			31.00
40.00	04000	SUBPROVIDER - IPF	6,369,165		6,369,165			40.00
41.00	04100	SUBPROVIDER - IRF	7,118,731		7,118,731			41.00
43.00	04300	NURSERY	1,325,119		1,325,119			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,527,462	20,835,945	41,363,407	0.196018	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,257,914	9,502,598	10,760,512	0.229769	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,550,210	266,416	4,816,626	0.452061	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,199,506	76,314,031	89,513,537	0.126292	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	393,864	23,141,188	23,535,052	0.128445	0.000000	55.00
60.00	06000	LABORATORY	19,308,682	46,221,156	65,529,838	0.119825	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	12,134,938	3,628,860	15,763,798	0.224059	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	13,423,499	8,934,385	22,357,884	0.300105	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	11,792,144	21,065,556	32,857,700	0.198118	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	88,120	5,161,077	5,249,197	0.214202	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,886,825	4,701,580	8,588,405	0.916430	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,723,590	6,449,432	16,173,022	0.436578	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,115,367	52,492,287	72,607,654	0.289948	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	141,543	19,989,840	20,131,383	0.251714	0.000000	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03950	INPATIENT DIALYSIS	1,074,533	88,161	1,162,694	0.711532	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,320,114	1,320,114	2.451592	0.000000	90.00
90.01	09001	OUTPATIENT PSYCH	192,095	6,845,759	7,037,854	0.288498	0.000000	90.01
91.00	09100	EMERGENCY	10,466,620	44,526,853	54,993,473	0.209083	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,872,727	12,305,729	16,178,456	0.250406	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	564,850	564,850	0.325332	0.000000	96.00
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	647,891	4,123,255	4,771,146			116.00
200.00		Subtotal (see instructions)	199,365,049	368,479,072	567,844,121			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	199,365,049	368,479,072	567,844,121			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.196018	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	ENDOSCOPY	0.229769	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	55.00
60.00	06000	LABORATORY	0.119825	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	66.00
69.00	06900	ELECTROCARDIOLOGY	0.203761	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251804	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	2.451592	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	90.01
91.00	09100	EMERGENCY	0.209381	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	96.00
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: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:14 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	15,091,679		15,091,679	0	15,091,679	30.00
31.00	03100	INTENSIVE CARE UNIT	8,472,312		8,472,312	0	8,472,312	31.00
40.00	04000	SUBPROVIDER - IPF	2,663,915		2,663,915	0	2,663,915	40.00
41.00	04100	SUBPROVIDER - IRF	5,003,777		5,003,777	0	5,003,777	41.00
43.00	04300	NURSERY	615,410		615,410	0	615,410	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,107,972		8,107,972	0	8,107,972	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	2,472,430		2,472,430	0	2,472,430	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,177,408		2,177,408	0	2,177,408	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,304,884		11,304,884	0	11,304,884	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,022,949		3,022,949	0	3,022,949	55.00
60.00	06000	LABORATORY	7,852,119		7,852,119	0	7,852,119	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,532,027	0	3,532,027	0	3,532,027	65.00
66.00	06600	PHYSICAL THERAPY	6,709,722	0	6,709,722	0	6,709,722	66.00
69.00	06900	ELECTROCARDIOLOGY	6,509,713		6,509,713	185,398	6,695,111	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,124,391		1,124,391	0	1,124,391	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,870,668		7,870,668	0	7,870,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,060,781		7,060,781	0	7,060,781	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,052,419		21,052,419	0	21,052,419	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,067,341		5,067,341	1,826	5,069,167	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	827,294		827,294	0	827,294	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,236,381		3,236,381	0	3,236,381	90.00
90.01	09001	OUTPATIENT PSYCH	2,030,407		2,030,407	0	2,030,407	90.01
91.00	09100	EMERGENCY	11,498,218		11,498,218	16,358	11,514,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,051,184		4,051,184		4,051,184	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	183,764		183,764	0	183,764	96.00
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	1,443,713		1,443,713		1,443,713	116.00
200.00		Subtotal (see instructions)	148,982,878	0	148,982,878	203,582	149,186,460	200.00
201.00		Less Observation Beds	4,051,184		4,051,184		4,051,184	201.00
202.00		Total (see instructions)	144,931,694	0	144,931,694	203,582	145,135,276	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:14 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	21,630,376		21,630,376			30.00
31.00	03100	INTENSIVE CARE UNIT	16,124,128		16,124,128			31.00
40.00	04000	SUBPROVIDER - IPF	6,369,165		6,369,165			40.00
41.00	04100	SUBPROVIDER - IRF	7,118,731		7,118,731			41.00
43.00	04300	NURSERY	1,325,119		1,325,119			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,527,462	20,835,945	41,363,407	0.196018	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,257,914	9,502,598	10,760,512	0.229769	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,550,210	266,416	4,816,626	0.452061	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,199,506	76,314,031	89,513,537	0.126292	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	393,864	23,141,188	23,535,052	0.128445	0.000000	55.00
60.00	06000	LABORATORY	19,308,682	46,221,156	65,529,838	0.119825	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	12,134,938	3,628,860	15,763,798	0.224059	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	13,423,499	8,934,385	22,357,884	0.300105	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	11,792,144	21,065,556	32,857,700	0.198118	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	88,120	5,161,077	5,249,197	0.214202	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,886,825	4,701,580	8,588,405	0.916430	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,723,590	6,449,432	16,173,022	0.436578	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,115,367	52,492,287	72,607,654	0.289948	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	141,543	19,989,840	20,131,383	0.251714	0.000000	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03950	INPATIENT DIALYSIS	1,074,533	88,161	1,162,694	0.711532	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,320,114	1,320,114	2.451592	0.000000	90.00
90.01	09001	OUTPATIENT PSYCH	192,095	6,845,759	7,037,854	0.288498	0.000000	90.01
91.00	09100	EMERGENCY	10,466,620	44,526,853	54,993,473	0.209083	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,872,727	12,305,729	16,178,456	0.250406	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	564,850	564,850	0.325332	0.000000	96.00
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	647,891	4,123,255	4,771,146			116.00
200.00		Subtotal (see instructions)	199,365,049	368,479,072	567,844,121			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	199,365,049	368,479,072	567,844,121			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:14 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
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	ENDOSCOPY	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	76.00
76.01	03950	INPATIENT DIALYSIS	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	OUTPATIENT PSYCH	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		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
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 ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,636,458	0	2,636,458	18,887	139.59	30.00
31.00	INTENSIVE CARE UNIT	1,041,828		1,041,828	7,286	142.99	31.00
40.00	SUBPROVIDER - IPF	470,506	0	470,506	4,366	107.77	40.00
41.00	SUBPROVIDER - IRF	657,012	0	657,012	7,587	86.60	41.00
43.00	NURSERY	13,671		13,671	1,003	13.63	43.00
200.00	Total (lines 30 through 199)	4,819,475		4,819,475	39,129		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,405	1,592,024				30.00
31.00	INTENSIVE CARE UNIT	1,436	205,334				31.00
40.00	SUBPROVIDER - IPF	1,626	175,234				40.00
41.00	SUBPROVIDER - IRF	6,464	559,782				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	20,931	2,532,374				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	735,603	41,363,407	0.017784	11,719,668	208,423	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	419,625	10,760,512	0.038997	730,002	28,468	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,315	4,816,626	0.008162	8,744	71	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,170,395	89,513,537	0.013075	8,187,231	107,048	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	270,806	23,535,052	0.011506	329,297	3,789	55.00
60.00	06000	LABORATORY	307,093	65,529,838	0.004686	11,304,820	52,974	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	216,149	15,763,798	0.013712	6,697,550	91,837	65.00
66.00	06600	PHYSICAL THERAPY	772,368	22,357,884	0.034546	3,889,917	134,381	66.00
69.00	06900	ELECTROCARDIOLOGY	648,184	32,857,700	0.019727	7,039,598	138,870	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	258,226	5,249,197	0.049193	38,836	1,910	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108,796	8,588,405	0.012668	2,161,993	27,388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,427	16,173,022	0.007323	6,147,023	45,015	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	442,542	72,607,654	0.006095	10,560,967	64,369	73.00
75.00	07500	ASC (NON-DISTINCT PART)	138,051	20,131,383	0.006858	7,787	53	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	278,582	1,162,694	0.239600	739,806	177,258	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	128,604	1,320,114	0.097419	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	116,716	7,037,854	0.016584	84,732	1,405	90.01
91.00	09100	EMERGENCY	819,314	54,993,473	0.014898	6,756,698	100,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	707,726	16,178,456	0.043745	2,277,037	99,609	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,602	564,850	0.025851	0	0	96.00
200.00		Total (lines 50 through 199)	7,711,124	510,505,456		78,681,706	1,283,529	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/29/2018 4:14 pm

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		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	18,887	0.00	11,405	30.00
31.00	03100	INTENSIVE CARE UNIT		0	7,286	0.00	1,436	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,366	0.00	1,626	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	7,587	0.00	6,464	41.00
43.00	04300	NURSERY		0	1,003	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	39,129		20,931	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	313,012	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	317,789	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	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
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	630,801	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	41,363,407	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	10,760,512	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,816,626	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	313,012	313,012	89,513,537	0.003497	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	23,535,052	0.000000	55.00
60.00	06000	LABORATORY	0	317,789	317,789	65,529,838	0.004850	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,763,798	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	22,357,884	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,857,700	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,249,197	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,588,405	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,173,022	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,607,654	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	20,131,383	0.000000	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	1,162,694	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,320,114	0.000000	90.00
90.01	09001	OUTPATIENT PSYCH	0	0	0	7,037,854	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	54,993,473	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,178,456	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	564,850	0.000000	96.00
200.00		Total (lines 50 through 199)	0	630,801	630,801	510,505,456		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

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		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	11,719,668	0	7,965,582	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	730,002	0	3,508,374	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	8,744	0	25,630	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003497	8,187,231	28,631	29,777,531	104,132	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	329,297	0	13,093,678	0	55.00
60.00	06000	LABORATORY	0.004850	11,304,820	54,828	8,017,215	38,883	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,697,550	0	1,342,615	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,889,917	0	457,232	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,039,598	0	10,599,868	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	38,836	0	1,975,986	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,161,993	0	1,910,391	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,147,023	0	3,293,056	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,560,967	0	24,719,756	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	7,787	0	6,838,275	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.000000	739,806	0	47,448	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	5,550	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.000000	84,732	0	4,426,256	0	90.01
91.00	09100	EMERGENCY	0.000000	6,756,698	0	11,774,019	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,277,037	0	4,882,851	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		78,681,706	83,459	134,661,313	143,015	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Hospital | PPS

		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	0.196018	7,965,582	0	0	1,561,397	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.229769	3,508,374	0	0	806,116	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	25,630	0	0	11,586	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	29,777,531	0	0	3,760,664	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	13,093,678	0	0	1,681,817	55.00
60.00	06000	LABORATORY	0.119825	8,017,215	236	0	960,663	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	1,342,615	0	0	300,825	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	457,232	0	0	137,218	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198118	10,599,868	0	0	2,100,025	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	1,975,986	0	0	423,260	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	1,910,391	0	0	1,750,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	3,293,056	0	0	1,437,676	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	24,719,756	0	50,305	7,167,444	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251714	6,838,275	0	0	1,721,290	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	47,448	0	0	33,761	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.451592	5,550	0	0	13,606	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	4,426,256	0	0	1,276,966	90.01
91.00	09100	EMERGENCY	0.209083	11,774,019	0	0	2,461,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	4,882,851	0	0	1,222,695	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	0	0	0	0	96.00
200.00		Subtotal (see instructions)		134,661,313	236	50,305	28,829,496	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		134,661,313	236	50,305	28,829,496	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	28	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,586		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03950	INPATIENT DIALYSIS	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT PSYCH	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	28	14,586		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	28	14,586		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	735,603	41,363,407	0.017784	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	419,625	10,760,512	0.038997	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,315	4,816,626	0.008162	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,170,395	89,513,537	0.013075	20,918	274	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	270,806	23,535,052	0.011506	0	0	55.00
60.00	06000	LABORATORY	307,093	65,529,838	0.004686	125,976	590	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	216,149	15,763,798	0.013712	94,910	1,301	65.00
66.00	06600	PHYSICAL THERAPY	772,368	22,357,884	0.034546	23,740	820	66.00
69.00	06900	ELECTROCARDIOLOGY	648,184	32,857,700	0.019727	10,312	203	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	258,226	5,249,197	0.049193	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108,796	8,588,405	0.012668	2,039	26	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,427	16,173,022	0.007323	215	2	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	442,542	72,607,654	0.006095	297,378	1,813	73.00
75.00	07500	ASC (NON-DISTINCT PART)	138,051	20,131,383	0.006858	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	278,582	1,162,694	0.239600	3,600	863	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	128,604	1,320,114	0.097419	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	116,716	7,037,854	0.016584	0	0	90.01
91.00	09100	EMERGENCY	819,314	54,993,473	0.014898	46,392	691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	16,178,456	0.000000	4,086	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,602	564,850	0.025851	0	0	96.00
200.00		Total (lines 50 through 199)	7,003,398	510,505,456		629,566	6,583	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	313,012	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	317,789	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	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
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	630,801	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	41,363,407	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	10,760,512	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,816,626	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	313,012	313,012	89,513,537	0.003497	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	23,535,052	0.000000	55.00
60.00	06000	LABORATORY	0	317,789	317,789	65,529,838	0.004850	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,763,798	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	22,357,884	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,857,700	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,249,197	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,588,405	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,173,022	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,607,654	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	20,131,383	0.000000	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	1,162,694	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,320,114	0.000000	90.00
90.01	09001	OUTPATIENT PSYCH	0	0	0	7,037,854	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	54,993,473	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,178,456	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	564,850	0.000000	96.00
200.00		Total (lines 50 through 199)	0	630,801	630,801	510,505,456		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003497	20,918	73	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.004850	125,976	611	626	3	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	94,910	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	23,740	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	10,312	0	277	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,039	0	4	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	215	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	297,378	0	429	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.000000	3,600	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	46,392	0	3,601	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	4,086	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		629,566	684	4,937	3	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IPF | PPS

		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	0.196018	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.229769	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	0	0	0	0	55.00
60.00	06000	LABORATORY	0.119825	626	0	0	75	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198118	277	0	0	55	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	4	0	0	4	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	429	0	801	124	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251714	0	0	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.451592	0	0	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.209083	3,601	0	0	753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	0	0	0	0	96.00
200.00		Subtotal (see instructions)		4,937	0	801	1,011	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		4,937	0	801	1,011	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 4:14 pm

Component CCN: 15-S042 | Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	232		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03950	INPATIENT DIALYSIS	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT PSYCH	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	232		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	232		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	735,603	41,363,407	0.017784	18,195	324	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	419,625	10,760,512	0.038997	24,719	964	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,315	4,816,626	0.008162	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,170,395	89,513,537	0.013075	306,828	4,012	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	270,806	23,535,052	0.011506	0	0	55.00
60.00	06000	LABORATORY	307,093	65,529,838	0.004686	1,192,339	5,587	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	216,149	15,763,798	0.013712	1,435,764	19,687	65.00
66.00	06600	PHYSICAL THERAPY	772,368	22,357,884	0.034546	6,757,146	233,432	66.00
69.00	06900	ELECTROCARDIOLOGY	648,184	32,857,700	0.019727	139,335	2,749	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	258,226	5,249,197	0.049193	2,436	120	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108,796	8,588,405	0.012668	166,001	2,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,427	16,173,022	0.007323	52,371	384	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	442,542	72,607,654	0.006095	1,402,671	8,549	73.00
75.00	07500	ASC (NON-DISTINCT PART)	138,051	20,131,383	0.006858	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	278,582	1,162,694	0.239600	21,603	5,176	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	128,604	1,320,114	0.097419	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	116,716	7,037,854	0.016584	827	14	90.01
91.00	09100	EMERGENCY	819,314	54,993,473	0.014898	48,193	718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	16,178,456	0.000000	13,982	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14,602	564,850	0.025851	0	0	96.00
200.00		Total (lines 50 through 199)	7,003,398	510,505,456		11,582,410	283,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	313,012	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	317,789	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	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
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	630,801	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	41,363,407	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	10,760,512	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,816,626	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	313,012	313,012	89,513,537	0.003497	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	23,535,052	0.000000	55.00
60.00	06000	LABORATORY	0	317,789	317,789	65,529,838	0.004850	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,763,798	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	22,357,884	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,857,700	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,249,197	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,588,405	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,173,022	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,607,654	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	20,131,383	0.000000	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	1,162,694	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,320,114	0.000000	90.00
90.01	09001	OUTPATIENT PSYCH	0	0	0	7,037,854	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	54,993,473	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,178,456	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	564,850	0.000000	96.00
200.00		Total (lines 50 through 199)	0	630,801	630,801	510,505,456		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	18,195	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	24,719	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003497	306,828	1,073	1,835	6	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.004850	1,192,339	5,783	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,435,764	0	189	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,757,146	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	139,335	0	277	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	2,436	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	166,001	0	1,976	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	52,371	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,402,671	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.000000	21,603	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.000000	827	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	48,193	0	1,298	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	13,982	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		11,582,410	6,856	5,575	6	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IRF | PPS

		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	0.196018	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.229769	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	1,835	0	0	232	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	0	0	0	0	55.00
60.00	06000	LABORATORY	0.119825	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	189	0	0	42	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198118	277	0	0	55	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	1,976	0	0	1,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	0	0	1,539	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251714	0	0	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.451592	0	0	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.209083	1,298	0	0	271	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	0	0	0	0	96.00
200.00		Subtotal (see instructions)		5,575	0	1,539	2,411	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		5,575	0	1,539	2,411	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 4:14 pm

Component CCN: 15-T042 | Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	446		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03950	INPATIENT DIALYSIS	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT PSYCH	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	446		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	446		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/29/2018 4:14 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	18,887	0.00	161	30.00
31.00	03100	INTENSIVE CARE UNIT		0	7,286	0.00	85	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,366	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	7,587	0.00	10	41.00
43.00	04300	NURSERY		0	1,003	0.00	12	43.00
200.00		Total (lines 30 through 199)		0	39,129		268	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	313,012	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	317,789	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	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
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	630,801	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	41,363,407	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	10,760,512	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,816,626	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	313,012	313,012	89,513,537	0.003497	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	23,535,052	0.000000	55.00
60.00	06000	LABORATORY	0	317,789	317,789	65,529,838	0.004850	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,763,798	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	22,357,884	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,857,700	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,249,197	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,588,405	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,173,022	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,607,654	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	20,131,383	0.000000	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	1,162,694	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,320,114	0.000000	90.00
90.01	09001	OUTPATIENT PSYCH	0	0	0	7,037,854	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	54,993,473	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,178,456	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	564,850	0.000000	96.00
200.00		Total (lines 50 through 199)	0	630,801	630,801	510,505,456		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:14 pm

Title XIX | 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	1,920,147	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	165,425	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	1,830,309	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003497	1,349,747	4,720	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	16,029	0	0	0	55.00
60.00	06000	LABORATORY	0.004850	2,248,657	10,906	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,175,322	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	359,981	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,075,761	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	19,840	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	331,794	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	374,217	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,486,686	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	6,840	0	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.000000	135,632	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.000000	4,803	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	1,393,610	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	324,062	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		15,218,862	15,626	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 4:14 pm

Title XIX | 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	0.196018	0	2,687,110	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.229769	0	838,972	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	0	136,028	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	0	11,690,684	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	0	1,908,323	0	0	55.00
60.00	06000	LABORATORY	0.119825	0	7,950,507	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	0	625,358	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	0	1,529,795	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198118	0	2,202,676	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	0	980,600	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	0	616,936	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	0	506,238	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	0	5,137,873	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251714	0	3,235,018	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	0	10,801	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.451592	0	71,780	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	0	1,015,380	0	0	90.01
91.00	09100	EMERGENCY	0.209083	0	14,627,094	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	0	2,813,302	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	58,584,475	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	58,584,475	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 4:14 pm

Title XIX | 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	526,722	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	192,770	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	61,493	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,476,440	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	245,115	0		55.00
60.00	06000	LABORATORY	952,670	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	140,117	0		65.00
66.00	06600	PHYSICAL THERAPY	459,099	0		66.00
69.00	06900	ELECTROCARDIOLOGY	436,390	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	210,046	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	565,379	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	221,012	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,489,716	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	814,299	0		75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03950	INPATIENT DIALYSIS	7,685	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	175,975	0		90.00
90.01	09001	OUTPATIENT PSYCH	292,935	0		90.01
91.00	09100	EMERGENCY	3,058,277	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	704,468	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	12,030,608	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	12,030,608	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 4:14 pm
	Title XVIII	Hospital	PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	18,887	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,887	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)	13,817	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)	11,405	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	15,091,679	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)	15,091,679	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)	15,091,679	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)	799.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,113,165	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)	9,113,165	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,472,312	7,286	1,162.82	1,436	1,669,810	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)	19,275,386	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	30,058,361	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)	1,797,358	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,366,988	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,164,346	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	26,894,015	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)	5,070	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	799.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,051,184	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,636,458	15,091,679	0.174696	4,051,184	707,726	90.00
91.00	Nursing School cost	0	15,091,679	0.000000	4,051,184	0	91.00
92.00	Allied health cost	0	15,091,679	0.000000	4,051,184	0	92.00
93.00	All other Medical Education	0	15,091,679	0.000000	4,051,184	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 4:14 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,366	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,366	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)	4,366	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)	1,626	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	2,663,915	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)	2,663,915	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,663,915	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)	610.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	992,104	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)	992,104	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1

Component CCN: 15-S042 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	149,713	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,141,817	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)	175,234	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,267	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	182,501	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	959,316	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	470,506	2,663,915	0.176622	0	0	90.00
91.00	Nursing School cost	0	2,663,915	0.000000	0	0	91.00
92.00	Allied health cost	0	2,663,915	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,663,915	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 4:14 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,587	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,587	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)	7,587	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)	6,464	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	5,003,777	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)	5,003,777	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)	5,003,777	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)	659.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,263,137	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)	4,263,137	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1

Component CCN: 15-T042 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,180,227	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,443,364	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)	559,782	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	290,675	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	850,457	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,592,907	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	657,012	5,003,777	0.131303	0	0	90.00
91.00	Nursing School cost	0	5,003,777	0.000000	0	0	91.00
92.00	Allied health cost	0	5,003,777	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,003,777	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:14 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)	18,887	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,887	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)	13,817	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)	161	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)	1,003	15.00
16.00	Nursery days (title V or XIX only)	12	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	15,091,679	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)	15,091,679	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)	15,091,679	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)	799.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	128,647	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)	128,647	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:14 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)	615,410	1,003	613.57	12	7,363	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,472,312	7,286	1,162.82	85	98,840	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)	3,933,114	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,167,964	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)	5,070	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	799.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,051,184	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:14 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	2,636,458	15,091,679	0.174696	4,051,184	707,726	90.00
91.00	Nursing School cost	0	15,091,679	0.000000	4,051,184	0	91.00
92.00	Allied health cost	0	15,091,679	0.000000	4,051,184	0	92.00
93.00	All other Medical Education	0	15,091,679	0.000000	4,051,184	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		12,807,454		30.00
31.00	03100	INTENSIVE CARE UNIT		10,098,282		31.00
40.00	04000	SUBPROVIDER - IPF		73,680		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196018	11,719,668	2,297,266	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.229769	730,002	167,732	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	8,744	3,953	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	8,187,231	1,033,982	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	329,297	42,297	55.00
60.00	06000	LABORATORY	0.119825	11,304,820	1,354,600	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	6,697,550	1,500,646	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	3,889,917	1,167,384	66.00
69.00	06900	ELECTROCARDIOLOGY	0.203761	7,039,598	1,434,396	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	38,836	8,319	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	2,161,993	1,981,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	6,147,023	2,683,655	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	10,560,967	3,062,131	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251804	7,787	1,961	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	739,806	526,396	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.451592	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	84,732	24,445	90.01
91.00	09100	EMERGENCY	0.209381	6,756,698	1,414,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	2,277,037	570,184	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		78,681,706	19,275,386	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)		78,681,706		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,497,688		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196018	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.229769	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	20,918	2,642	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	0	0	55.00
60.00	06000	LABORATORY	0.119825	125,976	15,095	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	94,910	21,265	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	23,740	7,124	66.00
69.00	06900	ELECTROCARDIOLOGY	0.203761	10,312	2,101	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	2,039	1,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	215	94	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	297,378	86,224	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251804	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	3,600	2,562	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.451592	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	0	0	90.01
91.00	09100	EMERGENCY	0.209381	46,392	9,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	4,086	1,023	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		629,566	149,713	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)		629,566		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		6,508,389		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196018	18,195	3,567	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.229769	24,719	5,680	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	306,828	38,750	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	0	0	55.00
60.00	06000	LABORATORY	0.119825	1,192,339	142,872	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	1,435,764	321,696	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	6,757,146	2,027,853	66.00
69.00	06900	ELECTROCARDIOLOGY	0.203761	139,335	28,391	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	2,436	522	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	166,001	152,128	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	52,371	22,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	1,402,671	406,702	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251804	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	21,603	15,371	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.451592	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	827	239	90.01
91.00	09100	EMERGENCY	0.209381	48,193	10,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	13,982	3,501	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,582,410	3,180,227	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)		11,582,410		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 4:14 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		2,770,991		30.00
31.00	03100	INTENSIVE CARE UNIT		1,895,178		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		634,239		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196018	1,920,147	376,383	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.229769	165,425	38,010	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	1,830,309	827,411	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	1,349,747	170,462	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	16,029	2,059	55.00
60.00	06000	LABORATORY	0.119825	2,248,657	269,445	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	1,175,322	263,341	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	359,981	108,032	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198118	1,075,761	213,128	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	19,840	4,250	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	331,794	304,066	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	374,217	163,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	2,486,686	721,010	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251714	6,840	1,722	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	135,632	96,507	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.451592	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	4,803	1,386	90.01
91.00	09100	EMERGENCY	0.209083	1,393,610	291,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	324,062	81,147	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,218,862	3,933,114	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)		15,218,862		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,630,594		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196018	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.229769	951	219	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	77,202	9,750	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	0	0	55.00
60.00	06000	LABORATORY	0.119825	173,838	20,830	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	48,639	10,898	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	42,576	12,777	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198118	12,839	2,544	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	3,757	805	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	8,908	8,164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	196,085	56,854	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251714	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	3,448	2,453	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.451592	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	0	0	90.01
91.00	09100	EMERGENCY	0.209083	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		568,243	125,294	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)		568,243		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 4:14 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		224,730		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.196018	696	136	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.229769	1,803	414	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.452061	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126292	17,565	2,218	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.128445	0	0	55.00
60.00	06000	LABORATORY	0.119825	25,927	3,107	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.224059	7,969	1,786	65.00
66.00	06600	PHYSICAL THERAPY	0.300105	184,494	55,368	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198118	3,348	663	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.214202	423	91	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.916430	6,680	6,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.436578	258	113	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289948	26,684	7,737	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.251714	0	0	75.00
76.00	03951	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.711532	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.451592	0	0	90.00
90.01	09001	OUTPATIENT PSYCH	0.288498	0	0	90.01
91.00	09100	EMERGENCY	0.209083	2,872	600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250406	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.325332	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		278,719	78,355	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)		278,719		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 4:14 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	16,855,677	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6,057,956	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	546,925	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	1,764,143	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	112.59	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.63	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.55	31.00
32.00	Sum of lines 30 and 31	20.18	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.86	33.00
34.00	Disproportionate share adjustment (see instructions)	335,685	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 4:14 pm
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000103263	0.000195298	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	617,253	1,321,522	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	461,671	333,096	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	794,767		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	24,591,010		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	24,591,010	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,917,186	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	7,712	53.00
54.00	Special add-on payments for new technologies	1,036	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	83,459	58.00
59.00	Total (sum of amounts on lines 49 through 58)	26,600,403	59.00
60.00	Primary payer payments	2,330	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	26,598,073	61.00
62.00	Deductibles billed to program beneficiaries	2,786,532	62.00
63.00	Coinsurance billed to program beneficiaries	65,800	63.00
64.00	Allowable bad debts (see instructions)	163,871	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	106,516	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	97,492	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	23,852,257	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	45,938	70.93
70.94	HRR adjustment amount (see instructions)	-64,083	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Date/Time Prepared: 5/29/2018 4:14 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		264,911	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		23,569,201	71.00
71.01	Sequestration adjustment (see instructions)		471,384	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		23,100,976	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-3,159	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		266,155	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2018 4:14 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	16,855,677	0	16,855,677		16,855,677	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,057,956	0		6,057,956	6,057,956	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	546,925	0	484,213	62,712	546,925	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,764,143	0	1,267,458	496,685	1,764,143	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0586	0.0586	0.0586	0.0586		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	335,685	0	246,936	88,749	335,685	11.00
11.01	Uncompensated care payments	36.00	794,767	0	461,671	333,096	794,767	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	24,591,010	0	18,048,497	6,542,513	24,591,010	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	24,591,010	0	18,048,497	6,542,513	24,591,010	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,917,186	0	1,418,978	498,208	1,917,186	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	0	1,036	0	1,036	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2018 4:14 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	19,468,511	7,040,721	26,509,232	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,839,231	0	1,350,248	488,983	1,839,231	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	77,955	0	68,730	9,225	77,955	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,917,186	0	1,418,978	498,208	1,917,186	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2018 4:14 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	16,855,677	16,855,677		16,855,677	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,057,956		6,057,956	6,057,956	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	546,925	484,213	62,712	546,925	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,764,143	1,267,458	496,685	1,764,143	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0586	0.0586	0.0586		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	335,685	246,936	88,749	335,685	11.00
11.01	Uncompensated care payments	36.00	794,767	461,671	333,096	794,767	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	24,591,010	18,048,497	6,542,513	24,591,010	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	24,591,010	18,048,497	6,542,513	24,591,010	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,917,186	1,418,978	498,208	1,917,186	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	1,036	0	1,036	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			19,468,511	7,040,721	26,509,232	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2018 4:14 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,839,231	1,350,248	488,983	1,839,231	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	77,955	68,730	9,225	77,955	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,917,186	1,418,978	498,208	1,917,186	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	45,938	20,114	25,824	45,938	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-64,083	-40,457	-23,626	-64,083	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		194,482	70,429	264,911	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part B Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	14,614	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	28,686,481	2.00
3.00	OPPS payments	24,769,555	3.00
4.00	Outlier payment (see instructions)	276,005	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	143,015	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	14,614	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	50,541	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)	50,541	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)	50,541	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	35,927	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)	14,614	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)	25,188,575	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	47	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,877,452	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)	20,325,690	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)	20,325,690	30.00
31.00	Primary payer payments	2,349	31.00
32.00	Subtotal (line 30 minus line 31)	20,323,341	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)	540,343	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	351,223	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	421,245	36.00
37.00	Subtotal (see instructions)	20,674,564	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)	20,674,564	40.00
40.01	Sequestration adjustment (see instructions)	413,491	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	20,220,625	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	40,448	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 4:14 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	232	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,008	2.00
3.00	OPPS payments	2,335	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	3	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	232	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	801	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)	801	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)	801	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	569	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)	232	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)	2,338	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	393	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,177	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,177	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,177	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,177	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)	2,177	40.00
40.01	Sequestration adjustment (see instructions)	44	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	551	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	1,582	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 4:14 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	446	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,405	2.00
3.00	OPPS payments	699	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	6	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	446	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,539	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)	1,539	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)	1,539	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,093	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)	446	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)	705	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	11	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	1,140	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)	1,140	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,140	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,140	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)	1,140	40.00
40.01	Sequestration adjustment (see instructions)	23	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,172	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-55	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: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Hospital | 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		23,100,976		20,220,625	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		23,100,976		20,220,625	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		40,448	6.01
6.02	SETTLEMENT TO PROGRAM		3,159		0	6.02
7.00	Total Medicare program liability (see instructions)		23,097,817		20,261,073	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IPF | 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		1,138,311		551	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,138,311		551	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		6,095		1,582	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,144,406		2,133	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 4:14 pm

Title XVIII | Subprovider - IRF | 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		9,380,044		1,172	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,380,044		1,172	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		10,595		55	6.02
7.00	Total Medicare program liability (see instructions)		9,369,449		1,117	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: 15-0042	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/29/2018 4:14 pm
	Title XVIII	Hospital	PPS

			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: 15-0042 Component CCN: 15-S042	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 5/29/2018 4:14 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,387,296	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	11.961644	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,387,296	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,387,296	16.00
17.00	Primary payer payments	1,408	17.00
18.00	Subtotal (line 16 less line 17).	1,385,888	18.00
19.00	Deductibles	206,500	19.00
20.00	Subtotal (line 18 minus line 19)	1,179,388	20.00
21.00	Coinsurance	17,766	21.00
22.00	Subtotal (line 20 minus line 21)	1,161,622	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,392	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	5,455	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,773	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,167,077	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	684	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,167,761	31.00
31.01	Sequestration adjustment (see instructions)	23,355	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,138,311	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	6,095	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 5/29/2018 4:14 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	9,377,569	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0302	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	197,867	3.00
4.00	Outlier Payments	192,294	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	20.786301	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	9,767,730	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	9,767,730	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	9,767,730	19.00
20.00	Deductibles	185,528	20.00
21.00	Subtotal (line 19 minus line 20)	9,582,202	21.00
22.00	Coinsurance	37,506	22.00
23.00	Subtotal (line 21 minus line 22)	9,544,696	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14,016	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	9,110	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,732	26.00
27.00	Subtotal (sum of lines 23 and 25)	9,553,806	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	6,856	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	9,560,662	32.00
32.01	Sequestration adjustment (see instructions)	191,213	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	9,380,044	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-10,595	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	192,294	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/29/2018 4:14 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	36,046,101	0	0	0	1.00
2.00	Temporary investments	32,247,299	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	51,865,683	0	0	0	4.00
5.00	Other receivable	6,599,589	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,826,281	0	0	0	6.00
7.00	Inventory	2,359,749	0	0	0	7.00
8.00	Prepaid expenses	4,804,199	0	0	0	8.00
9.00	Other current assets	5,465,665	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)	131,562,004	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,912,648	0	0	0	12.00
13.00	Land improvements	11,445,289	0	0	0	13.00
14.00	Accumulated depreciation	-5,906,527	0	0	0	14.00
15.00	Buildings	160,623,658	0	0	0	15.00
16.00	Accumulated depreciation	-59,443,318	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	215,508,394	0	0	0	23.00
24.00	Accumulated depreciation	-126,879,937	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	2,459,629	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)	204,719,836	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	938,311	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	938,311	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	337,220,151	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	15,208,230	0	0	0	37.00
38.00	Salaries, wages, and fees payable	13,807,836	0	0	0	38.00
39.00	Payroll taxes payable	1,460,512	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,261,232	0	0	0	40.00
41.00	Deferred income	58,723	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	37,796,533	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	113,876,659	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	113,876,659	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	151,673,192	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	185,546,959				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)	185,546,959	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	337,220,151	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/29/2018 4:14 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		190,647,196		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,100,237				2.00
3.00	Total (sum of line 1 and line 2)		185,546,959		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		185,546,959		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)		185,546,959		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2018 4:14 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	24,843,455		24,843,455	1.00
2.00	SUBPROVIDER - IPF	7,396,423		7,396,423	2.00
3.00	SUBPROVIDER - IRF	8,345,169		8,345,169	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)	40,585,047		40,585,047	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	18,013,905		18,013,905	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)	18,013,905		18,013,905	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	58,598,952		58,598,952	17.00
18.00	Ancillary services	135,326,884	277,563,496	412,890,380	18.00
19.00	Outpatient services	12,321,555	94,358,668	106,680,223	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	647,658	4,123,699	4,771,357	26.00
27.00	ASC	162,630	24,071,667	24,234,297	27.00
27.01	PHYSICIAN OFFICE	9,373,656	50,492,356	59,866,012	27.01
27.02	MH RESIDENTIAL	0	222,200	222,200	27.02
27.03	COMMUNITY MENTAL HEALTH CENTER	49,975	7,669,200	7,719,175	27.03
27.04	PHARMACY MISC INCOME	0	976,126	976,126	27.04
27.05	MENTAL HEALTH OVERHEAD	0	1,999,789	1,999,789	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	216,481,310	461,477,201	677,958,511	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		244,649,888		29.00
30.00	NURSING HOME OPERATING EXPENSES	91,217,648			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)		91,217,648		36.00
37.00	LTC IGT EXPENSE	3,306,157			37.00
38.00	MISC EXPENSE	1,304,221			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)		4,610,378		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		331,257,158		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/29/2018 4:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	677,958,511	1.00
2.00	Less contractual allowances and discounts on patients' accounts	475,524,063	2.00
3.00	Net patient revenues (line 1 minus line 2)	202,434,448	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	331,257,158	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-128,822,710	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	7,993	6.00
7.00	Income from investments	3,729,517	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	1,094,003	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	11,269,247	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	NURSING HOME REVENUE	103,327,240	24.00
24.01	DSH SETTLEMENT	3,637,894	24.01
24.02	EE PHARMACY CHARGES	656,579	24.02
25.00	Total other income (sum of lines 6-24)	123,722,473	25.00
26.00	Total (line 5 plus line 25)	-5,100,237	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)	-5,100,237	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O | Date/Time Prepared: 5/29/2018 4:14 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*		10,075	10,075	-10,075	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	156,851	156,851	-156,851	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	500,449	65,293	565,742	-292,408	273,334	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	3,134	3,134	0	3,134	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	284	284	0	284	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	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	26,817	26,817	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	2,531	2,531	27.00
28.00	REGISTERED NURSE**	0	0	0	160,793	160,793	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	43,257	43,257	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	0	59,010	59,010	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	12,505	12,505	-4,002	8,503	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	241,197	241,197	0	241,197	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	500,449	489,339	989,788	-170,928	818,860	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: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O | Date/Time Prepared: 5/29/2018 4:14 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*	-71	273,263		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	3,134		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	284		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	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	26,817		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	2,531		27.00
28.00	REGISTERED NURSE**	0	160,793		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	43,257		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	59,010		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	8,503		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	241,197		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	-71	818,789		100.00

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

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

Provider CCN: 15-0042 Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-1 Date/Time Prepared: 5/29/2018 4:14 pm

Hospice I

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

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

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

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

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

Provider CCN: 15-0042 Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-2 Date/Time Prepared: 5/29/2018 4:14 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	2,284	2,284	27.00
28.00	REGISTERED NURSE	0	0	0	145,148	145,148	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	39,048	39,048	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	53,268	53,268	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	11,288	11,288	-3,613	7,675	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	217,729	217,729	0	217,729	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	229,017	229,017	236,135	465,152	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	2,284		27.00
28.00	REGISTERED NURSE	0	145,148		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	39,048		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	53,268		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	7,675		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	217,729		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	465,152		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: 15-0042 Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-3 Date/Time Prepared: 5/29/2018 4:14 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	13	13	27.00
28.00	REGISTERED NURSE	0	0	0	804	804	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	216	216	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	295	295	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	63	63	-20	43	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	1,206	1,206	0	1,206	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	1,269	1,269	1,308	2,577	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	13		27.00
28.00	REGISTERED NURSE	0	804		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	216		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	295		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	43		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	1,206		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	2,577		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: 15-0042 Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-4 | Date/Time Prepared: 5/29/2018 4:14 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	234	234	27.00
28.00	REGISTERED NURSE	0	0	0	14,841	14,841	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	3,993	3,993	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	5,447	5,447	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	1,154	1,154	-369	785	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	22,262	22,262	0	22,262	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	23,416	23,416	24,146	47,562	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	234		27.00
28.00	REGISTERED NURSE	0	14,841		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	3,993		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	5,447		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	785		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	22,262		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	47,562		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: 15-0042 Hospice CCN: 15-1526

Period: From 01/01/2017 To 12/31/2017

Worksheet O-5

Date/Time Prepared: 5/29/2018 4:14 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	104,981	104,981	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	990	990	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	196,985	196,985	3.00
4.00	ADMINISTRATIVE & GENERAL	273,263	147,135	420,398	4.00
5.00	PLANT OPERATION & MAINTENANCE	3,134	67,851	70,985	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	34,949	34,949	7.00
8.00	DIETARY	284	0	284	8.00
9.00	NURSING ADMINISTRATION	0	72,026	72,026	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	12.00
13.00	VOLUNTEER SERVICE COORDINATION	26,817		26,817	13.00
14.00	PHARMACY	0	7	7	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	465,152		465,152	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,577		2,577	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	47,562		47,562	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	818,789	624,924	1,443,713	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0042 Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I Date/Time Prepared: 5/29/2018 4:14 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	104,981	104,981				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	990		990			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	196,985	0	0	196,985		3.00
4.00	ADMINISTRATIVE & GENERAL	420,398	0	0	92,444	512,842	4.00
5.00	PLANT OPERATION & MAINTENANCE	70,985	0	0	0	70,985	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	34,949	0	0	0	34,949	7.00
8.00	DIETARY	284	0	0	0	284	8.00
9.00	NURSING ADMINISTRATION	72,026	0	0	0	72,026	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	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	26,817	0	0	0	26,817	13.00
14.00	PHARMACY	7	0	0	0	7	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	465,152			94,368	559,520	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,577	5,420	51	523	8,571	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	47,562	99,561	939	9,650	157,712	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	1,443,713	104,981	990	196,985	1,443,713	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0042 Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I Date/Time Prepared: 5/29/2018 4:14 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	512,842					4.00
5.00	PLANT OPERATION & MAINTENANCE	39,108	110,093				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	19,254	0		54,203		7.00
8.00	DIETARY	156	0		0	440	8.00
9.00	NURSING ADMINISTRATION	39,681	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	14,774	0		0		13.00
14.00	PHARMACY	4	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	308,255					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	4,722	5,683	0	2,798	23	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	86,888	104,410	0	51,405	417	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	512,842	110,093	0	54,203	440	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I | Date/Time Prepared: 5/29/2018 4:14 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	111,707					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	41,591	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	100,842	0	0	0	37,545	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	560	0	0	0	209	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	10,305	0	0	0	3,837	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	111,707	0	0	0	41,591	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I | Date/Time Prepared: 5/29/2018 4:14 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	11					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	10	0	0		1,006,172	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	22,566	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1	0	0	0	414,975	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	11	0	0	0	1,443,713	100.00

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

Provider CCN: 15-0042
Hospice CCN: 15-1526

Period:
From 01/01/2017
To 12/31/2017

Worksheet O-6
Part II
Date/Time Prepared:
5/29/2018 4:14 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	3,971					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		3,971				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	500,449			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	234,858	-512,842	930,871	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	70,985	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	34,949	7.00
8.00	DIETARY	0	0	0	0	284	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	72,026	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	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	26,817	13.00
14.00	PHARMACY	0	0	0	0	7	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			239,748	0	559,520	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	205	205	1,328	0	8,571	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,766	3,766	24,515	0	157,712	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)	104,981	990	196,985		512,842	100.00
101.00	UNIT COST MULTIPLIER	26.436918	0.249307	0.393617		0.550927	101.00

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

Provider CCN: 15-0042
Hospice CCN: 15-1526

Period:
From 01/01/2017
To 12/31/2017

Worksheet O-6
Part II
Date/Time Prepared:
5/29/2018 4:14 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	3,971					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		3,971			7.00
8.00	DIETARY	0		0	698		8.00
9.00	NURSING ADMINISTRATION	0		0		7,176	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					6,478	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	205	0	205	36	36	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,766	0	3,766	662	662	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)	110,093	0	54,203	440	111,707	100.00
101.00	UNIT COST MULTIPLIER	27.724251	0.000000	13.649710	0.630372	15.566750	101.00

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

Provider CCN: 15-0042
Hospice CCN: 15-1526

Period:
From 01/01/2017
To 12/31/2017

Worksheet O-6
Part II
Date/Time Prepared:
5/29/2018 4:14 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			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	7,176		13.00
14.00	PHARMACY			0	0	7,176	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	6,478	6,478	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	36	36	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	662	662	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	0	41,591	11	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	5.795847	0.001533	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS | Provider CCN: 15-0042 Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part II Date/Time Prepared: 5/29/2018 4:14 pm

Hospice I

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

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

Provider CCN: 15-0042 Hospice CCN: 15-1526

Period: From 01/01/2017 To 12/31/2017

Worksheet O-7

Date/Time Prepared: 5/29/2018 4:14 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	0.300105	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.289948	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.325332	0	0	0	5.00
6.00	LABORATORY	60.00	0.119825	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.916430	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY - THERAPEUTIC	55.00	0.128445	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	76.00	0.000000	0	0	0	10.00
10.01	INPATIENT DIALYSIS	76.01	0.711532	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-8 | Date/Time Prepared: 5/29/2018 4:14 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)			1,006,172	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			6,478	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			155.32	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	4,917	121		9.00
10.00	Program cost (line 8 times line 9)	763,708	18,794		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)			22,566	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			36	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			626.83	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	17	0		14.00
15.00	Program cost (line 13 times line 14)	10,656	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)			414,975	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			662	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			626.85	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	472	17		19.00
20.00	Program cost (line 18 times line 19)	295,873	10,656		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,443,713	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			7,176	22.00
23.00	Average cost per diem (line 21 divided by line 22)			201.19	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0042	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/29/2018 4:14 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,839,231	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	77,955	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	58.04	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,917,186	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00