

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: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/23/2018 1:17 pm
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for Full or "L" for Low.

Contractor use only 5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended

6. Date Received:  
7. Contractor No.  
8.  Initial Report for this Provider CCN  
9.  Final Report for this Provider CCN

10. NPR Date:  
11. Contractor's Vendor Code: 4  
12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/23/2018 Time: 1:17 pm

**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 KING'S DAUGHTERS' HOSPITAL ( 15-0069 ) 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		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-201,811	4,695	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	-201,811	4,695	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: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 1:12 pm					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box: 447 State: IN Zip Code: 47250- County: JEFFERSON		3.00		4.00					
1.00 Street: ONE KINGS DAUGHTERS DRIVE		2.00 City: MADISON									
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
3.00 Hospital and Hospital-Based Component Identification:											
3.00	Hospital	KING'S DAUGHTERS' HOSPITAL	150069	99915	1	06/17/1966	N	P	O	3.00	
4.00	Subprovider - IPF									4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital-Based SNF									9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA	KING'S DAUGHTERS' HOSPITAL HHA	157141	99915		03/08/1985	N	P	N	12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice	KING'S DAUGHTERS'	151535	99915		09/01/1995				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)				2				21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.				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)				Y		Y		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.				3		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.				772	655	66	50	909	79	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.				0	0	0	0	0		25.00

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		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.	1				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.	1	10/01/2015			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.	1				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.	01/01/2017	12/31/2017			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					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 Criteria 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
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	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.						61.10	0.00
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.						61.20	0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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)						62.00	0.00
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) <u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>						62.01	0.00
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)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	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. 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)						64.00	0.000000

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

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
<b>Long Term Care Hospital PPS</b>					
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
<b>TEFRA Providers</b>					
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	
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
<b>Rural Providers</b>					
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	
<b>Miscellaneous Cost Reporting Information</b>								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				0			118.00
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	1,094,433		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
DO NOT USE THIS LINE								
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.				Y	Y		119.00 120.00
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
<b>Transplant Center Information</b>								
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: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 1:12 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	
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	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						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	
						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	
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	
168.01	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	
						1.00	
						Endi ng	
						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: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 1:12 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. 1, 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: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 1:12 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				
		1.00	2.00				
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				
		1.00	2.00				
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	C				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					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)	N		N			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)	Y	03/14/2018	Y	03/14/2018		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: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 1:12 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				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		
<b>Cost Report Preparer Contact Information</b>					
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.	LUCIA		GERBER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.992.3524		LGERBER@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 1:12 pm
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0069

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	82	29,930	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)		82	29,930	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	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)		88	32,120	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	1	365			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)		89				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: 15-0069

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2018 1:12 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)	6,199	1,345	10,258			1.00
2.00 HMO and other (see instructions)	1,125	718				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,199	1,345	10,258			7.00
8.00 INTENSIVE CARE UNIT	771	157	1,248			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		232	1,127			13.00
14.00 Total (see instructions)	6,970	1,734	12,633	0.00	779.09	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	5,312	703	8,187	0.00	14.99	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	27	0	30	0.00	0.89	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	794.97	27.00
28.00 Observation Bed Days		522	2,447			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			148			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	79	162			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: 15-0069

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	1,756	412	3,240	1.00
2.00 HMO and other (see instructions)				278	197		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		1,756	412	3,240	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							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: 15-0069

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/23/2018 1:12 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	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	51,722,385	483,931	52,206,316	1,653,546.13	31.57
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		436,447	0	436,447	5,113.56	85.35
4.00	Physician-Part A - Administrative		10,000	0	10,000	126.00	79.37
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		3,084,569	0	3,084,569	13,631.00	226.29
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		21,469,261	11,195	21,480,456	524,016.89	40.99
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		361,534	0	361,534	8,036.08	44.99
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		510,881	0	510,881	3,891.72	131.27
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		7,572,846	0	7,572,846		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		4,454,091	0	4,454,091		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		66,825	0	66,825		
22.00	Physician Part A - Administrative		1,778	0	1,778		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		372,812	0	372,812		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0069

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/23/2018 1:12 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	30,823	0	30,823	1,968.60	15.66	26.00
27.00	Administrative & General	5.00	6,474,406	483,931	6,958,337	280,045.61	24.85	27.00
28.00	Administrative & General under contract (see inst.)		448,249	0	448,249	3,451.50	129.87	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	634,581	0	634,581	28,349.30	22.38	30.00
31.00	Laundry & Linen Service	8.00	42,017	0	42,017	4,157.80	10.11	31.00
32.00	Housekeeping	9.00	658,503	0	658,503	59,439.22	11.08	32.00
33.00	Housekeeping under contract (see instructions)		242,577	0	242,577	9,251.32	26.22	33.00
34.00	Dietary	10.00	654,226	-210,780	443,446	33,666.90	13.17	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	210,780	210,780	11,956.00	17.63	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	422,458	0	422,458	11,771.72	35.89	38.00
39.00	Central Services and Supply	14.00	77,940	0	77,940	5,589.50	13.94	39.00
40.00	Pharmacy	15.00	755,691	0	755,691	20,895.04	36.17	40.00
41.00	Medical Records & Medical Records Library	16.00	507,392	0	507,392	24,655.15	20.58	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0069

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/23/2018 1:12 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	48,892,195	483,931	49,376,126	1,647,504.39	29.97	1.00
2.00	Excluded area salaries (see instructions)	21,469,261	11,195	21,480,456	524,016.89	40.99	2.00
3.00	Subtotal salaries (line 1 minus line 2)	27,422,934	472,736	27,895,670	1,123,487.50	24.83	3.00
4.00	Subtotal other wages & related costs (see inst.)	872,415	0	872,415	11,927.80	73.14	4.00
5.00	Subtotal wage-related costs (see inst.)	7,574,624	0	7,574,624	0.00	27.15	5.00
6.00	Total (sum of lines 3 thru 5)	35,869,973	472,736	36,342,709	1,135,415.30	32.01	6.00
7.00	Total overhead cost (see instructions)	10,948,863	483,931	11,432,794	495,197.66	23.09	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2018 1:12 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
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)	1,880,762	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	6,107,362	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)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,045,242	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	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)	225,185	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	3,191,132	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	18,670	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
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	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,468,353	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Prepared: 5/23/2018 1:12 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	361,534	12,468,353	1.00
2.00	Hospital	361,534	12,468,353	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0069 Component CCN: 15-7141			Period: From 01/01/2017 To 12/31/2017		Worksheet S-4 Date/Time Prepared: 5/23/2018 1:12 pm		
					Home Health Agency I		PPS		
					1.00				
0.00	County				JEFFERSON		0.00		
		Title V	Title XVIII	Title XIX	Other	Total			
		1.00	2.00	3.00	4.00	5.00			
HOME HEALTH AGENCY STATISTICAL DATA									
1.00	Home Health Aide Hours	0	1,070	0	645	1,715		1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	382.00	0.00	230.00	612.00		2.00	
					Number of Employees (Full Time Equivalent)				
		Enter the number of hours in your normal work week			Staff	Contract	Total		
		0			1.00	2.00	3.00		
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES									
3.00	Administrator and Assistant Administrator(s)	40.00			0.00	0.00	0.00		3.00
4.00	Director(s) and Assistant Director(s)				0.96	0.00	0.96		4.00
5.00	Other Administrative Personnel				9.38	0.00	9.38		5.00
6.00	Direct Nursing Service				0.52	0.00	0.52		6.00
7.00	Nursing Supervisor				0.00	0.00	0.00		7.00
8.00	Physical Therapy Service				2.59	0.00	2.59		8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00		9.00
10.00	Occupational Therapy Service				0.70	0.00	0.70		10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00		11.00
12.00	Speech Pathology Service				0.06	0.00	0.06		12.00
13.00	Speech Pathology Supervisor				0.00	0.00	0.00		13.00
14.00	Medical Social Service				0.00	0.00	0.00		14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00		15.00
16.00	Home Health Aide				0.82	0.00	0.82		16.00
17.00	Home Health Aide Supervisor				0.00	0.00	0.00		17.00
18.00	Other (specify)				0.00	0.00	0.00		18.00
HOME HEALTH AGENCY CBSA CODES									
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				2				19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).				31140				20.00
20.01					99915				20.01
		Full Episodes			LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA									
21.00	Skilled Nursing Visits	1,908	193	114	71	2,286		21.00	
22.00	Skilled Nursing Visit Charges	445,500	45,114	26,664	16,614	533,892		22.00	
23.00	Physical Therapy Visits	2,017	21	47	35	2,120		23.00	
24.00	Physical Therapy Visit Charges	421,113	4,359	5,643	7,315	438,430		24.00	
25.00	Occupational Therapy Visits	508	16	7	6	537		25.00	
26.00	Occupational Therapy Visit Charges	117,694	3,712	1,624	1,392	124,422		26.00	
27.00	Speech Pathology Visits	38	0	1	1	40		27.00	
28.00	Speech Pathology Visit Charges	9,070	0	239	239	9,548		28.00	
29.00	Medical Social Service Visits	1	0	0	0	1		29.00	
30.00	Medical Social Service Visit Charges	316	0	0	0	316		30.00	
31.00	Home Health Aide Visits	299	25	2	2	328		31.00	
32.00	Home Health Aide Visit Charges	40,798	3,410	274	274	44,756		32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,771	255	171	115	5,312		33.00	
34.00	Other Charges	0	0	0	0	0		34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,034,491	56,595	34,444	25,834	1,151,364		35.00	
36.00	Total Number of Episodes (standard/non outlier)	336		57	12	405		36.00	
37.00	Total Number of Outlier Episodes		0		0	0		37.00	
38.00	Total Non-Routine Medical Supply Charges	13,911	835	576	0	15,322		38.00	

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 15-0069 Hospice CCN: 15-1535	Period: From 01/01/2017 To 12/31/2017	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/23/2018 1:12 pm
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		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	
<b>PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015</b>								
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	
<b>Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015</b>								
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
<b>PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015</b>					
10.00	Hospice Continuous Home Care	0	0	0	0
11.00	Hospice Routine Home Care	1,500	111	130	1,741
12.00	Hospice Inpatient Respite Care	17	0	0	17
13.00	Hospice General Inpatient Care	13	0	0	13
14.00	Total Hospice Days	1,530	111	130	1,771
<b>PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015</b>					
15.00	Hospice Inpatient Respite Care	0	0	0	0
16.00	Hospice General Inpatient Care	0	0	0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/23/2018 1:12 pm
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.237228	1.00	
<b>Medicaid (see instructions for each line)</b>						
2.00	Net revenue from Medicaid			9,410,153	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			627,702	5.00	
6.00	Medicaid charges			46,023,529	6.00	
7.00	Medicaid cost (line 1 times line 6)			10,918,070	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)			880,215	8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>						
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>						
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	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>						
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)			880,215	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,810,936	345,006	3,155,942	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	666,833	345,006	1,011,839	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)	666,833	345,006	1,011,839	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)			9,093,548	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			391,838	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			602,827	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			8,490,721	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,225,226	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,237,065	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,117,280	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0069

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

Worksheet A  
Date/Time Prepared:  
5/23/2018 1:12 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		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		15,658,978		15,905,584	1.00	
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO		0	7,897	7,897	1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	2.00	
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	30,823	14,269,402	-1,081,677	13,218,548	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	6,474,406	10,970,594	-287,673	17,157,327	5.00	
7.00	00700	OPERATION OF PLANT	634,581	2,264,652	-66	2,899,167	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	42,017	284,961	326,978	326,978	8.00	
9.00	00900	HOUSEKEEPING	658,503	444,884	0	1,103,387	9.00	
10.00	01000	DIETARY	654,226	409,941	-342,855	721,312	10.00	
11.00	01100	CAFETERIA	0	0	342,855	342,855	11.00	
13.00	01300	NURSING ADMINISTRATION	422,458	499	422,957	422,957	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	77,940	1,795	79,735	79,735	14.00	
15.00	01500	PHARMACY	755,691	6,355,450	-5,933,777	1,177,364	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	507,392	236,037	743,429	743,429	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	436,447	436,447	19.00	
23.00	02300	RADIOLOGY SCHOOL	120,287	13,478	133,765	133,765	23.00	
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	23.01	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	4,817,157	733,993	5,551,150	-1,388,152	4,162,998	30.00
31.00	03100	INTENSIVE CARE UNIT	988,148	6,859	995,007	-538	994,469	31.00
43.00	04300	NURSERY	0	0	0	451,898	451,898	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,843,118	7,827,059	9,670,177	-6,806,973	2,863,204	50.00
51.00	05100	RECOVERY ROOM	291,130	37,699	328,829	-30,841	297,988	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	531,276	531,276	52.00
53.00	05300	ANESTHESIOLOGY	1,560,306	547,985	2,108,291	-536,096	1,572,195	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,588,877	864,801	3,453,678	-29,226	3,424,452	54.00
54.01	03630	ULTRA SOUND	101,329	23,419	124,748	-3,679	121,069	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	66,736	207,189	273,925	-387	273,538	54.02
55.00	03480	ONCOLOGY	1,209,102	1,156,926	2,366,028	-74,570	2,291,458	55.00
57.00	05700	CT SCAN	204,567	294,026	498,593	-14,813	483,780	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	126,251	133,251	259,502	-1,359	258,143	58.00
59.00	05900	CARDIAC CATHETERIZATION	150,466	189,204	339,670	-179,817	159,853	59.00
60.00	06000	LABORATORY	1,487,732	3,096,120	4,583,852	-1,487,171	3,096,681	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	294,613	294,613	0	294,613	62.00
65.00	06500	RESPIRATORY THERAPY	593,450	102,324	695,774	-84,262	611,512	65.00
66.00	06600	PHYSICAL THERAPY	1,661,478	122,762	1,784,240	-30,184	1,754,056	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03610	SLEEP LAB	133,708	79,300	213,008	-5,745	207,263	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,501,834	3,501,834	71.00
71.01	07101	IV SOLUTIONS	0	0	0	110,676	110,676	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,537,480	4,537,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,182,618	8,182,618	73.00
76.00	03140	CARDIOLOGY	425,277	105,705	530,982	-21,163	509,819	76.00
76.97	07697	CARDIAC REHABILITATION	69,315	7,089	76,404	-326	76,078	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	124,155	10,002	134,157	-9,141	125,016	90.00
91.00	09100	EMERGENCY	1,552,785	699,288	2,252,073	-231,751	2,020,322	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	1,410,886	194,839	1,605,725	-44,578	1,561,147	95.00
101.00	10100	HOME HEALTH AGENCY	919,060	95,152	1,014,212	0	1,014,212	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	55,293	65,645	120,938	0	120,938	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,758,650	67,805,921	100,564,571	-277,233	100,287,338	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MOB	1,650,651	272,328	1,922,979	0	1,922,979	194.01
194.02	07952	PHYSICIAN CLINICS	5,009,954	1,535,167	6,545,121	-42,046	6,503,075	194.02
194.03	07953	PHYS PRAC BUS OFC	641,369	14,802	656,171	735,522	1,391,693	194.03
194.04	07954	MOB - MAIN CAMPUS	334,867	4,177	339,044	0	339,044	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	3,991,755	331,689	4,323,444	-135,521	4,187,923	194.06
194.07	07957	KDH - MC ORTHOPEDICS	3,697,435	452,406	4,149,841	-193,601	3,956,240	194.07
194.08	07958	KDH - MC GENERAL SURGERY	1,196,562	245,185	1,441,747	0	1,441,747	194.08



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0069		Period: From 01/01/2017 To 12/31/2017	Worksheet A Date/Time Prepared: 5/23/2018 1:12 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 KDH - MC ENT	623,729	32,660	656,389	-72,601	583,788	194.09
194.10	07960 KDH - MC UROLOGY	103,868	598,125	701,993	0	701,993	194.10
194.11	07961 KDH - MC OB/GYN	1,713,545	610,126	2,323,671	-14,520	2,309,151	194.11
200.00	TOTAL (SUM OF LINES 118 through 199)	51,722,385	71,902,586	123,624,971	0	123,624,971	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0069

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

Worksheet A  
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5/23/2018 1:12 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-3,096,248	12,809,336	1.00
1.01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	7,897	1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1,278,992	11,939,556	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-3,647,449	13,509,878	5.00
7.00	00700 OPERATION OF PLANT	-21,531	2,877,636	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	326,978	8.00
9.00	00900 HOUSEKEEPING	0	1,103,387	9.00
10.00	01000 DIETARY	0	721,312	10.00
11.00	01100 CAFETERIA	-366,454	-23,599	11.00
13.00	01300 NURSING ADMINISTRATION	-29,385	393,572	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	79,735	14.00
15.00	01500 PHARMACY	0	1,177,364	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-127	743,302	16.00
17.00	01700 SOCIAL SERVICE	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	-436,447	0	19.00
23.00	02300 RADIOLOGY SCHOOL	-45,350	88,415	23.00
23.01	02301 HUB SITE - 3RD YEAR MED STUDENTS	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-215,522	3,947,476	30.00
31.00	03100 INTENSIVE CARE UNIT	0	994,469	31.00
43.00	04300 NURSERY	0	451,898	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	-350,593	2,512,611	50.00
51.00	05100 RECOVERY ROOM	-197,066	100,922	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	531,276	52.00
53.00	05300 ANESTHESIOLOGY	-1,671,598	-99,403	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-1,974,779	1,449,673	54.00
54.01	03630 ULTRA SOUND	0	121,069	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	273,538	54.02
55.00	03480 ONCOLOGY	-966,514	1,324,944	55.00
57.00	05700 CT SCAN	0	483,780	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	258,143	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	159,853	59.00
60.00	06000 LABORATORY	-177,461	2,919,220	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	294,613	62.00
65.00	06500 RESPIRATORY THERAPY	0	611,512	65.00
66.00	06600 PHYSICAL THERAPY	-2,945	1,751,111	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	03610 SLEEP LAB	0	207,263	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-171	3,501,663	71.00
71.01	07101 IV SOLUTIONS	0	110,676	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,537,480	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,182,618	73.00
76.00	03140 RADIOLOGY	-627	509,192	76.00
76.97	07697 CARDIAC REHABILITATION	0	76,078	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	125,016	90.00
91.00	09100 EMERGENCY	-167,684	1,852,638	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	-3,040	1,558,107	95.00
101.00	10100 HOME HEALTH AGENCY	0	1,014,212	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE	0	0	113.00
116.00	11600 HOSPICE	0	120,938	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-14,649,983	85,637,355	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950 OTHER NON-REIMBURSABLE	0	0	194.00
194.01	07951 MOB	0	1,922,979	194.01
194.02	07952 PHYSICIAN CLINICS	0	6,503,075	194.02
194.03	07953 PHYS PRAC BUS OFC	0	1,391,693	194.03
194.04	07954 MOB - MAIN CAMPUS	0	339,044	194.04
194.05	07955 ONCOLOGY - NONREIMBURSABLE	0	0	194.05
194.06	07956 KDH - MC FAMILY PRACTICE	0	4,187,923	194.06
194.07	07957 KDH - MC ORTHOPEDICS	0	3,956,240	194.07
194.08	07958 KDH - MC GENERAL SURGERY	0	1,441,747	194.08
194.09	07959 KDH - MC ENT	0	583,788	194.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0069		Period: From 01/01/2017 To 12/31/2017	Worksheet A Date/Time Prepared: 5/23/2018 1:12 pm
Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
194.10 07960	KDH - MC UROLOGY	0	701,993		194.10
194.11 07961	KDH - MC OB/GYN	0	2,309,151		194.11
200.00	TOTAL (SUM OF LINES 118 through 199)	-14,649,983	108,974,988		200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - CAFETERIA</b>					
1.00	CAFETERIA	11.00	210,780	132,075	1.00
	O		210,780	132,075	
<b>B - MEDICAL IMAGING TIME</b>					
1.00	PHYSICIAN CLINICS	194.02	11,195	0	1.00
	TOTALS		11,195	0	
<b>C - DEPRECIATION</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01	0	7,897	1.00
	O		0	7,897	
<b>D - NURSERY- L&amp;D</b>					
1.00	NURSERY	43.00	438,497	13,401	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	515,521	15,755	2.00
	O		954,018	29,156	
<b>E - CRNA EXPENSE</b>					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	436,447	0	1.00
	O		436,447	0	
<b>F - PHYSICIAN BILLING AND COLLECTIONS</b>					
1.00	PHYS PRAC BUS OFC	194.03	0	735,522	1.00
	O		0	735,522	
<b>G - EMPLOYEE BENEFITS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	483,931	0	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
	O		483,931	0	
<b>I - MED/SURG SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,501,834	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
	TOTALS		0	3,501,834	
<b>J - IV SOLUTIONS</b>					
1.00	IV SOLUTIONS	71.01	0	110,676	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
	TOTALS		0	110,676	
<b>K - IMPLANTS</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,537,480	1.00
	TOTALS		0	4,537,480	

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	<b>L - DRUGS</b>				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,182,618	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
	<b>TOTALS</b>		0	8,182,618	
	<b>M - INSURANCE</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	254,503	1.00
	0		0	254,503	
500.00	<b>Grand Total: Increases</b>		2,096,371	17,491,761	500.00

RECLASSIFICATIONS

Provider CCN: 15-0069

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

Worksheet A-6  
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA</b>							
1.00	DIETARY	10.00	210,780	132,075	0		1.00
	O		210,780	132,075			
<b>B - MEDICAL IMAGING TIME</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	11,195	0	0		1.00
	TOTALS		11,195	0			
<b>C - DEPRECIATION</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	7,897	9		1.00
	O		0	7,897			
<b>D - NURSERY- L&amp;D</b>							
1.00	ADULTS & PEDIATRICS	30.00	954,018	29,156	0		1.00
2.00	O	0.00	0	0	0		2.00
	O		954,018	29,156			
<b>E - CRNA EXPENSE</b>							
1.00	ANESTHESIOLOGY	53.00	436,447	0	0		1.00
	O		436,447	0			
<b>F - PHYSICIAN BILLING AND COLLECTIONS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	735,522	0		1.00
	O		0	735,522			
<b>G - EMPLOYEE BENEFITS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,447	0		1.00
2.00	PHYSICIAN CLINICS	194.02	0	53,241	0		2.00
3.00	KDH - MC FAMILY PRACTICE	194.06	0	135,521	0		3.00
4.00	KDH - MC ORTHOPEDICS	194.07	0	193,601	0		4.00
5.00	KDH - MC ENT	194.09	0	72,601	0		5.00
6.00	KDH - MC OB/GYN	194.11	0	14,520	0		6.00
	O		0	483,931			
<b>I - MED/SURG SUPPLIES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,802	0		1.00
2.00	OPERATION OF PLANT	7.00	0	66	0		2.00
3.00	PHARMACY	15.00	0	13,693	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	388,578	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	538	0		5.00
6.00	OPERATING ROOM	50.00	0	2,243,482	0		6.00
7.00	RECOVERY ROOM	51.00	0	30,158	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	69,834	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,006	0		9.00
10.00	ULTRA SOUND	54.01	0	3,679	0		10.00
11.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	387	0		11.00
12.00	ONCOLOGY	55.00	0	73,713	0		12.00
13.00	CT SCAN	57.00	0	14,813	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,359	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	179,188	0		15.00
16.00	LABORATORY	60.00	0	106,038	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	49,422	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	26,945	0		18.00
19.00	SLEEP LAB	69.01	0	5,745	0		19.00
20.00	CARDIOLOGY	76.00	0	21,163	0		20.00
21.00	CARDIAC REHABILITATION	76.97	0	326	0		21.00
22.00	CLINIC	90.00	0	9,141	0		22.00
23.00	EMERGENCY	91.00	0	222,183	0		23.00
24.00	AMBULANCE SERVICES	95.00	0	32,575	0		24.00
	TOTALS		0	3,501,834			
<b>J - IV SOLUTIONS</b>							
1.00	PHARMACY	15.00	0	55,944	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	16,400	0		2.00
3.00	OPERATING ROOM	50.00	0	26,011	0		3.00
4.00	RECOVERY ROOM	51.00	0	683	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4	0		5.00
6.00	ONCOLOGY	55.00	0	857	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	629	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	22	0		8.00
9.00	EMERGENCY	91.00	0	9,568	0		9.00
10.00	AMBULANCE SERVICES	95.00	0	558	0		10.00
	TOTALS		0	110,676			
<b>K - IMPLANTS</b>							
1.00	OPERATING ROOM	50.00	0	4,537,480	0		1.00
	TOTALS		0	4,537,480			

Provider CCN: 15-0069

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

Worksheet A-6  
Date/Time Prepared:  
5/23/2018 1:12 pm

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>L - DRUGS</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	827,174	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	19,833	0		2.00
3.00	PHARMACY	15.00	0	5,864,140	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	29,815	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,021	0		5.00
6.00	LABORATORY	60.00	0	1,381,133	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	3,239	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	34,818	0		8.00
9.00	AMBULANCE SERVICES	95.00	0	11,445	0		9.00
	TOTALS		0	8,182,618			
<b>M - INSURANCE</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	254,503	9		1.00
	0		0	254,503			
500.00	Grand Total: Decreases		1,612,440	17,975,692			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	4,096,085	47,720	0	47,720	644,686	1.00
2.00	Land Improvements	841,699	0	0	0	294,900	2.00
3.00	Buildings and Fixtures	119,248,527	129,904	0	129,904	1,390,971	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	64,213,779	3,054,229	0	3,054,229	3,601,290	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	188,400,090	3,231,853	0	3,231,853	5,931,847	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	188,400,090	3,231,853	0	3,231,853	5,931,847	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	3,499,119	0				1.00
2.00	Land Improvements	546,799	0				2.00
3.00	Buildings and Fixtures	117,987,460	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	63,666,718	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	185,700,096	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	185,700,096	0				10.00



RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	10,235,213	63,488	5,348,712	0	11,565	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,235,213	63,488	5,348,712	0	11,565	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	15,658,978				1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	15,658,978				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0069

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/23/2018 1:12 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	NEW CAP REL COSTS-BLDG & FIXT	122,033,378	0	122,033,378	0.657153	0	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	63,666,718	0	63,666,718	0.342847	0	2.00
3.00	Total (sum of lines 1-2)	185,700,096	0	185,700,096	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	10,481,819	20,582	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	7,897	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,489,716	20,582	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,295,370	0	11,565	0	12,809,336	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0	7,897	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,295,370	0	11,565	0	12,817,233	3.00

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
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-152,704	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01 Investment income - NEW CAP REL COSTS-BLDG & FIXT HHA/HO (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01	0	1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-42,906	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-4,031	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-21,531	OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-5,725,757			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	-366,454	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-171	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-127	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - NEW CAP REL COSTS-BLDG & FIXT HHA/HO			NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1.01	0	26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-436,447	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00 RADIOLOGY TUITION	B	-45,350		RADIOLOGY SCHOOL	23.00	0 33.00
33.01 COPIER BUYOUT REVENUE	B	-197,066		RECOVERY ROOM	51.00	0 33.01
33.02 BAXTER PUMP REVENUE	B	-29,385		NURSING ADMINISTRATION	13.00	0 33.02
33.03 AMBULANCE REVENUE	B	-2,763		AMBULANCE SERVICES	95.00	0 33.03
33.04 ADVERTISING	A	-180,078		ADMINISTRATIVE & GENERAL	5.00	0 33.04
33.05 SELF-INSURANCE	B	-1,169,900		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.05
33.06 HOSPITAL ASSOCIATION FEES	A	-8,343		ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 HAF MEDICAID	A	-2,729,746		ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08 PHYSICIAN RECRUITMENT	A	-341,094		ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09 PHYSICIAN LAB SALARY OFFSET	A	-177,461		LABORATORY	60.00	0 33.09
33.10 PHYSICIAN LAB BENEFIT OFFSET	A	-31,535		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.10
33.11 CRNA BENEFIT OFFSET	A	-77,557		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.11
33.12 DONATIONS	A	-8,939		ADMINISTRATIVE & GENERAL	5.00	0 33.12
33.13 GAIN/LOSS	B	-2,900,638		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,649,983				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: 15-0069

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

Worksheet A-8-2  
Date/Time Prepared:  
5/23/2018 1:12 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	375,218	375,218	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	215,522	215,522	0	211,500	0	2.00
3.00	50.00	OPERATING ROOM	350,593	350,593	0	246,400	0	3.00
4.00	53.00	ANESTHESIOLOGY	1,671,598	1,671,598	0	239,400	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,974,779	1,974,779	0	271,900	0	5.00
6.00	55.00	ONCOLOGY	966,514	966,514	0	211,500	0	6.00
7.00	60.00	LABORATORY	150,000	0	150,000	260,300	1,991	7.00
8.00	66.00	PHYSICAL THERAPY	2,945	2,945	0	211,500	0	8.00
9.00	69.01	SLEEP LAB	11,777	0	11,777	211,500	126	9.00
10.00	76.00	CARDIOLOGY	627	627	0	211,500	0	10.00
11.00	91.00	EMERGENCY	360,881	0	360,881	211,500	1,900	11.00
12.00	95.00	AMBULANCE SERVICES	989	0	989	211,500	7	12.00
200.00			6,081,443	5,557,796	523,647		4,024	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	55.00	ONCOLOGY	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	249,162	12,458	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	8.00
9.00	69.01	SLEEP LAB	12,812	641	0	0	0	9.00
10.00	76.00	CARDIOLOGY	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	193,197	9,660	0	0	0	11.00
12.00	95.00	AMBULANCE SERVICES	712	36	0	0	0	12.00
200.00			455,883	22,795	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	375,218		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	215,522		2.00
3.00	50.00	OPERATING ROOM	0	0	0	350,593		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	1,671,598		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,974,779		5.00
6.00	55.00	ONCOLOGY	0	0	0	966,514		6.00
7.00	60.00	LABORATORY	0	249,162	0	0		7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	2,945		8.00
9.00	69.01	SLEEP LAB	0	12,812	0	0		9.00
10.00	76.00	CARDIOLOGY	0	0	0	627		10.00
11.00	91.00	EMERGENCY	0	193,197	167,684	167,684		11.00
12.00	95.00	AMBULANCE SERVICES	0	712	277	277		12.00
200.00			0	455,883	167,961	5,725,757		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		1.00	1.01	2.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	12,809,336	12,809,336			1.00
1.01 00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	7,897	0	7,897		1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	11,939,556		0	11,939,556	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	13,509,878	1,494,679	0	1,403,669	5.00
7.00 00700	OPERATION OF PLANT	2,877,636	1,419,091	0	148,335	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	326,978	65,786	0	9,822	8.00
9.00 00900	HOUSEKEEPING	1,103,387	115,315	0	153,927	9.00
10.00 01000	DIETARY	721,312	217,204	0	103,657	10.00
11.00 01100	CAFETERIA	-23,599	87,841	0	49,270	11.00
13.00 01300	NURSING ADMINISTRATION	393,572	77,107	0	98,751	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	79,735	106,859	0	18,219	14.00
15.00 01500	PHARMACY	1,177,364	79,419	0	176,645	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	743,302	10,078	0	118,604	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	RADIOLOGY SCHOOL	88,415	22,815	0	28,117	23.00
23.01 02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	3,947,476	1,373,772	0	903,020	30.00
31.00 03100	INTENSIVE CARE UNIT	994,469	57,778	0	230,983	31.00
43.00 04300	NURSERY	451,898	67,477	0	102,500	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,512,611	606,846	0	430,834	50.00
51.00 05100	RECOVERY ROOM	100,922	47,458	0	68,053	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	531,276	0	0	120,505	52.00
53.00 05300	ANESTHESIOLOGY	-99,403	4,487	0	262,705	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,449,673	374,179	0	602,541	54.00
54.01 03630	ULTRA SOUND	121,069	0	0	23,686	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	273,538	16,671	0	15,600	54.02
55.00 03480	ONCOLOGY	1,324,944	426,953	0	282,631	55.00
57.00 05700	CT SCAN	483,780	30,891	0	47,818	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	258,143	37,276	0	29,512	58.00
59.00 05900	CARDIAC CATHETERIZATION	159,853	29,476	0	35,172	59.00
60.00 06000	LABORATORY	2,919,220	215,340	0	306,280	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	294,613	9,630	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	611,512	41,315	0	138,721	65.00
66.00 06600	PHYSICAL THERAPY	1,751,111	488,631	0	388,375	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01 03610	SLEEP LAB	207,263	28,958	0	31,255	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,501,663	0	0	0	71.00
71.01 07101	IV SOLUTIONS	110,676	0	0	0	71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	4,537,480	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	8,182,618	0	0	0	73.00
76.00 03140	CARDIOLOGY	509,192	208,713	0	99,410	76.00
76.97 07697	CARDIAC REHABILITATION	76,078	24,264	0	16,203	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	125,016	26,232	0	29,022	90.00
91.00 09100	EMERGENCY	1,852,638	479,036	0	362,968	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	1,558,107	163,326	0	329,799	95.00
101.00 10100	HOME HEALTH AGENCY	1,014,212	0	6,214	214,833	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	120,938	0	1,683	12,925	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	85,637,355	8,454,903	7,897	7,394,367	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01 07951	MOB	1,922,979	1,633,120	0	385,845	194.01
194.02 07952	PHYSICIAN CLINICS	6,503,075	1,197,987	0	1,186,154	194.02
194.03 07953	PHYS PRAC BUS OFC	1,391,693	34,135	0	149,922	194.03
194.04 07954	MOB - MAIN CAMPUS	339,044	0	0	78,276	194.04
194.05 07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06 07956	KDH - MC FAMILY PRACTICE	4,187,923	1,489,191	0	964,763	194.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B  
Part I  
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		
194.07 07957 KDH - MC ORTHOPEDICS	3,956,240	0	0	0	909,541	194.07
194.08 07958 KDH - MC GENERAL SURGERY	1,441,747	0	0	0	279,700	194.08
194.09 07959 KDH - MC ENT	583,788	0	0	0	162,769	194.09
194.10 07960 KDH - MC UROLOGY	701,993	0	0	0	24,279	194.10
194.11 07961 KDH - MC OB/GYN	2,309,151	0	0	0	403,940	194.11
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)	108,974,988	12,809,336	7,897	0	11,939,556	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B  
Part I  
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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	16,408,226	16,408,226				5.00
7.00	00700	4,445,062	787,923	5,232,985			7.00
8.00	00800	402,586	71,362	34,370	508,318		8.00
9.00	00900	1,372,629	243,309	60,247	0	1,676,185	9.00
10.00	01000	1,042,173	184,734	113,480	0	0	10.00
11.00	01100	113,512	20,121	45,893	0	0	11.00
13.00	01300	569,430	100,936	40,285	0	0	13.00
14.00	01400	204,813	36,305	55,829	0	16,450	14.00
15.00	01500	1,433,428	254,087	41,493	0	28,772	15.00
16.00	01600	871,984	154,566	5,266	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	139,347	24,700	11,920	0	2,378	23.00
23.01	02301	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	6,224,268	1,103,301	717,738	160,585	787,041	30.00
31.00	03100	1,283,230	227,463	30,187	0	41,225	31.00
43.00	04300	621,875	110,232	35,254	8,435	6,937	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,550,291	629,317	317,051	102,051	176,527	50.00
51.00	05100	216,433	38,364	24,795	12,714	0	51.00
52.00	05200	651,781	115,533	0	9,916	23,222	52.00
53.00	05300	167,789	29,742	2,344	0	0	53.00
54.00	05400	2,426,393	430,098	195,493	31,623	53,183	54.00
54.01	03630	144,755	25,659	0	3,531	10,075	54.01
54.02	03450	305,809	54,207	8,710	2,183	3,402	54.02
55.00	03480	2,034,528	360,636	223,065	14,462	77,330	55.00
57.00	05700	562,489	99,706	16,139	15,523	6,640	57.00
58.00	05800	324,931	57,597	19,475	3,488	5,450	58.00
59.00	05900	224,501	39,795	15,400	0	13,973	59.00
60.00	06000	3,440,840	609,916	112,506	0	46,510	60.00
62.00	06200	304,243	53,930	5,031	0	0	62.00
65.00	06500	791,548	140,308	21,585	0	0	65.00
66.00	06600	2,628,117	465,855	255,289	30,066	20,150	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03610	267,476	47,412	15,129	2,022	19,027	69.01
71.00	07100	3,501,663	620,698	0	0	0	71.00
71.01	07101	110,676	19,618	0	0	0	71.01
72.00	07200	4,537,480	804,305	0	0	0	72.00
73.00	07300	8,182,618	1,450,435	0	0	0	73.00
76.00	03140	817,315	144,876	109,044	17,091	7,069	76.00
76.97	07697	116,545	20,659	12,677	0	8,060	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	180,270	31,954	13,705	9	8,622	90.00
91.00	09100	2,694,642	477,647	250,276	75,023	116,771	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	2,051,232	363,597	85,331	11,768	0	95.00
101.00	10100	1,235,259	218,960	49,554	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	135,546	24,027	13,416	0	0	116.00
118.00		76,737,733	10,693,890	2,957,977	500,490	1,478,814	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	3,941,944	698,741	853,238	1,257	0	194.01
194.02	07952	8,887,216	1,575,355	625,897	2,687	0	194.02
194.03	07953	1,575,750	279,314	17,834	0	0	194.03
194.04	07954	417,320	73,973	0	0	197,371	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	6,641,877	1,177,326	778,039	126	0	194.06
194.07	07957	4,865,781	862,499	0	898	0	194.07
194.08	07958	1,721,447	305,140	0	761	0	194.08
194.09	07959	746,557	132,333	0	0	0	194.09
194.10	07960	726,272	128,738	0	0	0	194.10
194.11	07961	2,713,091	480,917	0	2,099	0	194.11



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	108,974,988	16,408,226	5,232,985	508,318	1,676,185	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part I Date/Time Prepared: 5/23/2018 1:12 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,340,387					10.00
11.00	01100	CAFETERIA	0	179,526				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	710,651			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,300	0	314,697		14.00
15.00	01500	PHARMACY	0	4,861	0	746	1,763,387	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,736	0	251	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	966	0	35	0	23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,253,181	36,973	310,426	4,583	0	30.00
31.00	03100	INTENSIVE CARE UNIT	87,206	13,102	110,005	17	0	31.00
43.00	04300	NURSERY	0	3,196	26,832	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	10,803	90,703	160,676	0	50.00
51.00	05100	RECOVERY ROOM	0	2,041	17,134	109	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,757	31,547	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,446	0	457	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,742	0	1,958	0	54.00
54.01	03630	ULTRA SOUND	0	625	0	476	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	580	0	72	0	54.02
55.00	03480	ONCOLOGY	0	6,647	0	479	0	55.00
57.00	05700	CT SCAN	0	1,840	0	4,012	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	898	0	548	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,131	0	128	0	59.00
60.00	06000	LABORATORY	0	14,909	0	1,236	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	5,346	0	1,261	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,027	0	326	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03610	SLEEP LAB	0	852	0	4	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	118,012	0	71.00
71.01	07101	IV SOLUTIONS	0	0	0	3,730	0	71.01
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	1,763,387	73.00
76.00	03140	CARDIOLOGY	0	4,120	0	155	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	718	0	11	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	813	0	18	0	90.00
91.00	09100	EMERGENCY	0	14,769	124,004	1,236	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	17,328	0	344	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	805	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,340,387	179,526	710,651	301,685	1,763,387	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	937	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	3,124	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	422	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	469	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	734	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	3,595	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	2,073	0	194.08
194.09	07959	KDH - MC ENT	0	0	0	151	0	194.09
194.10	07960	KDH - MC UROLOGY	0	0	0	676	0	194.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period:  
From 01/01/2017  
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
194.11	07961 KDH - MC OB/GYN	0	0	0	831	0	194.11
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)	1,340,387	179,526	710,651	314,697	1,763,387	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS	
		16.00	17.00	19.00	23.00	23.01	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,037,803				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
23.00	02300	RADIOLOGY SCHOOL	0	0	179,346		23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0		0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	36,172	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,587	0	0	0	31.00
43.00	04300	NURSERY	5,159	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	105,321	0	0	0	50.00
51.00	05100	RECOVERY ROOM	21,775	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,913	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,697	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,227	0	0	179,346	54.00
54.01	03630	ULTRA SOUND	6,464	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	19,961	0	0	0	54.02
55.00	03480	ONCOLOGY	23,948	0	0	0	55.00
57.00	05700	CT SCAN	54,119	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	14,187	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,919	0	0	0	59.00
60.00	06000	LABORATORY	103,908	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,171	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	26,777	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	40,374	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03610	SLEEP LAB	6,245	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,624	0	0	0	71.00
71.01	07101	IV SOLUTIONS	8,957	0	0	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,498	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	226,096	0	0	0	73.00
76.00	03140	CARDIOLOGY	37,650	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,251	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	557	0	0	0	90.00
91.00	09100	EMERGENCY	92,285	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	16,961	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,037,803	0	0	179,346	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	0	194.08
194.09	07959	KDH - MC ENT	0	0	0	0	194.09
194.10	07960	KDH - MC UROLOGY	0	0	0	0	194.10

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part I Date/Time Prepared: 5/23/2018 1:12 pm			
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS			
			16.00	17.00	19.00	23.00	23.01			
194.11	07961	KDH - MC OB/GYN	0	0	0	0	0	0	194.11	
200.00		Cross Foot Adjustments							0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,037,803	0	0	179,346	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

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

Worksheet B  
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5/23/2018 1:12 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
1.01	00101				1.01
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
19.00	01900				19.00
23.00	02300				23.00
23.01	02301				23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	10,634,268	0	10,634,268	30.00
31.00	03100	1,802,022	0	1,802,022	31.00
43.00	04300	817,920	0	817,920	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	5,142,740	0	5,142,740	50.00
51.00	05100	333,365	0	333,365	51.00
52.00	05200	841,669	0	841,669	52.00
53.00	05300	224,475	0	224,475	53.00
54.00	05400	3,355,063	0	3,355,063	54.00
54.01	03630	191,585	0	191,585	54.01
54.02	03450	394,924	0	394,924	54.02
55.00	03480	2,741,095	0	2,741,095	55.00
57.00	05700	760,468	0	760,468	57.00
58.00	05800	426,574	0	426,574	58.00
59.00	05900	301,847	0	301,847	59.00
60.00	06000	4,329,825	0	4,329,825	60.00
62.00	06200	370,375	0	370,375	62.00
65.00	06500	986,825	0	986,825	65.00
66.00	06600	3,453,204	0	3,453,204	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
69.00	06900	0	0	0	69.00
69.01	03610	358,167	0	358,167	69.01
71.00	07100	4,282,997	0	4,282,997	71.00
71.01	07101	142,981	0	142,981	71.01
72.00	07200	5,410,283	0	5,410,283	72.00
73.00	07300	11,622,536	0	11,622,536	73.00
76.00	03140	1,137,320	0	1,137,320	76.00
76.97	07697	160,921	0	160,921	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	235,948	0	235,948	90.00
91.00	09100	3,846,653	0	3,846,653	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	2,546,561	0	2,546,561	95.00
101.00	10100	1,504,578	0	1,504,578	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
116.00	11600	172,989	0	172,989	116.00
118.00		68,530,178	0	68,530,178	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
194.00	07950	0	0	0	194.00
194.01	07951	5,496,117	0	5,496,117	194.01
194.02	07952	11,094,279	0	11,094,279	194.02
194.03	07953	1,873,320	0	1,873,320	194.03
194.04	07954	689,133	0	689,133	194.04
194.05	07955	0	0	0	194.05
194.06	07956	8,598,102	0	8,598,102	194.06
194.07	07957	5,732,773	0	5,732,773	194.07
194.08	07958	2,029,421	0	2,029,421	194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period:  
From 01/01/2017  
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
194.09	07959 KDH - MC ENT	879,041	0	879,041	194.09
194.10	07960 KDH - MC UROLOGY	855,686	0	855,686	194.10
194.11	07961 KDH - MC OB/GYN	3,196,938	0	3,196,938	194.11
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	108,974,988	0	108,974,988	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0069

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,494,679	0	0	5.00
7.00 00700	OPERATION OF PLANT	0	1,419,091	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	65,786	0	0	8.00
9.00 00900	HOUSEKEEPING	0	115,315	0	0	9.00
10.00 01000	DIETARY	0	217,204	0	0	10.00
11.00 01100	CAFETERIA	0	87,841	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	77,107	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	106,859	0	0	14.00
15.00 01500	PHARMACY	0	79,419	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	10,078	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	RADIOLOGY SCHOOL	0	22,815	0	0	23.00
23.01 02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,373,772	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	57,778	0	0	31.00
43.00 04300	NURSERY	0	67,477	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	606,846	0	0	50.00
51.00 05100	RECOVERY ROOM	0	47,458	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	4,487	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	374,179	0	0	54.00
54.01 03630	ULTRA SOUND	0	0	0	0	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	16,671	0	0	54.02
55.00 03480	ONCOLOGY	0	426,953	0	0	55.00
57.00 05700	CT SCAN	0	30,891	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	37,276	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	29,476	0	0	59.00
60.00 06000	LABORATORY	0	215,340	0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	9,630	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	41,315	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	488,631	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01 03610	SLEEP LAB	0	28,958	0	0	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
71.01 07101	IV SOLUTIONS	0	0	0	0	71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03140	CARDIOLOGY	0	208,713	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	24,264	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	26,232	0	0	90.00
91.00 09100	EMERGENCY	0	479,036	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	163,326	0	0	95.00
101.00 10100	HOME HEALTH AGENCY	0	0	6,214	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	0	0	1,683	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	0	8,454,903	7,897	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01 07951	MOB	0	1,633,120	0	0	194.01
194.02 07952	PHYSICIAN CLINICS	0	1,197,987	0	0	194.02
194.03 07953	PHYS PRAC BUS OFC	0	34,135	0	0	194.03
194.04 07954	MOB - MAIN CAMPUS	0	0	0	0	194.04
194.05 07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06 07956	KDH - MC FAMILY PRACTICE	0	1,489,191	0	0	194.06
194.07 07957	KDH - MC ORTHOPEDICS	0	0	0	0	194.07



ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 1:12 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP		
		0	1.00	1.01		
194.08 07958 KDH - MC GENERAL SURGERY	0	0	0	0	0	194.08
194.09 07959 KDH - MC ENT	0	0	0	0	0	194.09
194.10 07960 KDH - MC UROLOGY	0	0	0	0	0	194.10
194.11 07961 KDH - MC OB/GYN	0	0	0	0	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	12,809,336	7,897	0	12,817,233	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 1:12 pm		
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			4.00	5.00	7.00	8.00	9.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,494,679			5.00
7.00	00700	OPERATION OF PLANT	0	71,774	1,490,865		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,501	9,792	82,079	8.00
9.00	00900	HOUSEKEEPING	0	22,164	17,164	0	154,643
10.00	01000	DIETARY	0	16,828	32,330	0	0
11.00	01100	CAFETERIA	0	1,833	13,075	0	0
13.00	01300	NURSING ADMINISTRATION	0	9,195	11,477	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,307	15,906	0	1,518
15.00	01500	PHARMACY	0	23,146	11,821	0	2,654
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,080	1,500	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	RADIOLOGY SCHOOL	0	2,250	3,396	0	219
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	100,503	204,482	25,932	72,613
31.00	03100	INTENSIVE CARE UNIT	0	20,720	8,600	0	3,803
43.00	04300	NURSERY	0	10,041	10,044	1,362	640
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	57,327	90,327	16,478	16,286
51.00	05100	RECOVERY ROOM	0	3,495	7,064	2,053	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,524	0	1,601	2,142
53.00	05300	ANESTHESIOLOGY	0	2,709	668	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,179	55,695	5,106	4,907
54.01	03630	ULTRA SOUND	0	2,337	0	570	930
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	4,938	2,481	352	314
55.00	03480	ONCOLOGY	0	32,852	63,551	2,335	7,134
57.00	05700	CT SCAN	0	9,083	4,598	2,506	613
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,247	5,548	563	503
59.00	05900	CARDIAC CATHETERIZATION	0	3,625	4,387	0	1,289
60.00	06000	LABORATORY	0	55,559	32,053	0	4,291
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,913	1,433	0	0
65.00	06500	RESPIRATORY THERAPY	0	12,781	6,150	0	0
66.00	06600	PHYSICAL THERAPY	0	42,436	72,731	4,855	1,859
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03610	SLEEP LAB	0	4,319	4,310	327	1,755
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	56,541	0	0	0
71.01	07101	IV SOLUTIONS	0	1,787	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	73,267	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	132,125	0	0	0
76.00	03140	CARDIOLOGY	0	13,197	31,066	2,760	652
76.97	07697	CARDIAC REHABILITATION	0	1,882	3,612	0	744
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	2,911	3,904	1	795
91.00	09100	EMERGENCY	0	43,510	71,303	12,114	10,773
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	33,121	24,311	1,900	0
101.00	10100	HOME HEALTH AGENCY	0	19,946	14,118	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	2,189	3,822	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	974,142	842,719	80,815	136,434
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0
194.01	07951	MOB	0	63,651	243,086	203	0
194.02	07952	PHYSICIAN CLINICS	0	143,504	178,317	434	0
194.03	07953	PHYS PRAC BUS OFC	0	25,444	5,081	0	0
194.04	07954	MOB - MAIN CAMPUS	0	6,738	0	0	18,209
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0
194.06	07956	KDH - MC FAMILY PRACTICE	0	107,246	221,662	20	0
194.07	07957	KDH - MC ORTHOPEDICS	0	78,568	0	145	0
194.08	07958	KDH - MC GENERAL SURGERY	0	27,796	0	123	0
194.09	07959	KDH - MC ENT	0	12,055	0	0	0
194.10	07960	KDH - MC UROLOGY	0	11,727	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0069

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
194.11	07961 KDH - MC OB/GYN	0	43,808	0	339	0	194.11
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)	0	1,494,679	1,490,865	82,079	154,643	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/23/2018 1:12 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	266,362					10.00
11.00	01100	CAFETERIA	0	90,812				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	97,779			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	658	0	128,248		14.00
15.00	01500	PHARMACY	0	2,459	0	304	119,803	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,901	0	102	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	RADIOLOGY SCHOOL	0	489	0	14	0	23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	249,032	18,704	42,710	1,868	0	30.00
31.00	03100	INTENSIVE CARE UNIT	17,330	6,627	15,136	7	0	31.00
43.00	04300	NURSERY	0	1,617	3,692	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	5,464	12,480	65,478	0	50.00
51.00	05100	RECOVERY ROOM	0	1,032	2,358	45	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,901	4,341	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	731	0	186	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,940	0	798	0	54.00
54.01	03630	ULTRA SOUND	0	316	0	194	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	293	0	29	0	54.02
55.00	03480	ONCOLOGY	0	3,362	0	195	0	55.00
57.00	05700	CT SCAN	0	931	0	1,635	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	454	0	223	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	572	0	52	0	59.00
60.00	06000	LABORATORY	0	7,542	0	504	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,704	0	514	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,590	0	133	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03610	SLEEP LAB	0	431	0	2	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48,094	0	71.00
71.01	07101	IV SOLUTIONS	0	0	0	1,520	0	71.01
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	119,803	73.00
76.00	03140	CARDIOLOGY	0	2,084	0	63	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	363	0	5	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	411	0	7	0	90.00
91.00	09100	EMERGENCY	0	7,471	17,062	504	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	8,765	0	140	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	328	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	266,362	90,812	97,779	122,944	119,803	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	382	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	1,273	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	172	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	191	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	299	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	1,465	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	845	0	194.08
194.09	07959	KDH - MC ENT	0	0	0	62	0	194.09
194.10	07960	KDH - MC UROLOGY	0	0	0	276	0	194.10

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/23/2018 1:12 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
194.11	07961	KDH - MC OB/GYN	0	0	0	339	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	11,937	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	266,362	102,749	97,779	128,248	119,803	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 1:12 pm		
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS
			16.00	17.00	19.00	23.00	23.01
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,661				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
23.00	02300	RADIOLOGY SCHOOL	0	0		29,183	23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0			0 23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	999	0			30.00
31.00	03100	INTENSIVE CARE UNIT	265	0			31.00
43.00	04300	NURSERY	143	0			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	2,910	0			50.00
51.00	05100	RECOVERY ROOM	602	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163	0			52.00
53.00	05300	ANESTHESIOLOGY	627	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	697	0			54.00
54.01	03630	ULTRA SOUND	179	0			54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	551	0			54.02
55.00	03480	ONCOLOGY	662	0			55.00
57.00	05700	CT SCAN	1,495	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	392	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	191	0			59.00
60.00	06000	LABORATORY	2,871	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	198	0			62.00
65.00	06500	RESPIRATORY THERAPY	740	0			65.00
66.00	06600	PHYSICAL THERAPY	1,115	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
69.01	03610	SLEEP LAB	173	0			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,178	0			71.00
71.01	07101	IV SOLUTIONS	247	0			71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,892	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,236	0			73.00
76.00	03140	CARDIOLOGY	1,040	0			76.00
76.97	07697	CARDIAC REHABILITATION	62	0			76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	15	0			90.00
91.00	09100	EMERGENCY	2,549	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	469	0			95.00
101.00	10100	HOME HEALTH AGENCY	0	0			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,661	0	0	0	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0			190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0			194.00
194.01	07951	MOB	0	0			194.01
194.02	07952	PHYSICIAN CLINICS	0	0			194.02
194.03	07953	PHYS PRAC BUS OFC	0	0			194.03
194.04	07954	MOB - MAIN CAMPUS	0	0			194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0			194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0			194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0			194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0			194.08
194.09	07959	KDH - MC ENT	0	0			194.09
194.10	07960	KDH - MC UROLOGY	0	0			194.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0069

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	RADIOLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS	
		16.00	17.00	19.00	23.00	23.01	
194.11	07961 KDH - MC OB/GYN	0	0				194.11
200.00	Cross Foot Adjustments			0	29,183		0 200.00
201.00	Negative Cost Centers	0	0	0	0		0 201.00
202.00	TOTAL (sum lines 118 through 201)	28,661	0	0	29,183		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 1:12 pm
Cost Center	Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
1.01	00101					1.01
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700					17.00
19.00	01900					19.00
23.00	02300					23.00
23.01	02301					23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	2,090,615	0	2,090,615		30.00
31.00	03100	130,266	0	130,266		31.00
43.00	04300	95,016	0	95,016		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	873,596	0	873,596		50.00
51.00	05100	64,107	0	64,107		51.00
52.00	05200	20,672	0	20,672		52.00
53.00	05300	9,408	0	9,408		53.00
54.00	05400	486,501	0	486,501		54.00
54.01	03630	4,526	0	4,526		54.01
54.02	03450	25,629	0	25,629		54.02
55.00	03480	537,044	0	537,044		55.00
57.00	05700	51,752	0	51,752		57.00
58.00	05800	50,206	0	50,206		58.00
59.00	05900	39,592	0	39,592		59.00
60.00	06000	318,160	0	318,160		60.00
62.00	06200	16,174	0	16,174		62.00
65.00	06500	64,204	0	64,204		65.00
66.00	06600	618,350	0	618,350		66.00
67.00	06700	0	0	0		67.00
68.00	06800	0	0	0		68.00
69.00	06900	0	0	0		69.00
69.01	03610	40,275	0	40,275		69.01
71.00	07100	105,813	0	105,813		71.00
71.01	07101	3,554	0	3,554		71.01
72.00	07200	75,159	0	75,159		72.00
73.00	07300	258,164	0	258,164		73.00
76.00	03140	259,575	0	259,575		76.00
76.97	07697	30,932	0	30,932		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	34,276	0	34,276		90.00
91.00	09100	644,322	0	644,322		91.00
92.00	09200		0			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	232,032	0	232,032		95.00
101.00	10100	40,606	0	40,606		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300					113.00
116.00	11600	7,694	0	7,694		116.00
118.00		7,228,220	0	7,228,220		118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0		190.00
194.00	07950	0	0	0		194.00
194.01	07951	1,940,442	0	1,940,442		194.01
194.02	07952	1,521,515	0	1,521,515		194.02
194.03	07953	64,832	0	64,832		194.03
194.04	07954	25,138	0	25,138		194.04
194.05	07955	0	0	0		194.05
194.06	07956	1,818,418	0	1,818,418		194.06
194.07	07957	80,178	0	80,178		194.07
194.08	07958	28,764	0	28,764		194.08



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0069

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
194.09	07959 KDH - MC ENT	12,117	0	12,117	194.09
194.10	07960 KDH - MC UROLOGY	12,003	0	12,003	194.10
194.11	07961 KDH - MC OB/GYN	44,486	0	44,486	194.11
200.00	Cross Foot Adjustments	29,183	0	29,183	200.00
201.00	Negative Cost Centers	11,937	0	11,937	201.00
202.00	TOTAL (sum lines 118 through 201)	12,817,233	0	12,817,233	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
	1.00	1.01	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	371,122				1.00
1.01 00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	3,492			1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP			374,614		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	51,077,654	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	43,305	0	43,305	6,004,922	5.00
7.00 00700	OPERATION OF PLANT	41,115	0	41,115	634,581	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,906	0	1,906	42,017	8.00
9.00 00900	HOUSEKEEPING	3,341	0	3,341	658,503	9.00
10.00 01000	DIETARY	6,293	0	6,293	443,446	10.00
11.00 01100	CAFETERIA	2,545	0	2,545	210,780	11.00
13.00 01300	NURSING ADMINISTRATION	2,234	0	2,234	422,458	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,096	0	3,096	77,940	14.00
15.00 01500	PHARMACY	2,301	0	2,301	755,691	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	292	0	292	507,392	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	RADIOLOGY SCHOOL	661	0	661	120,287	23.00
23.01 02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	39,802	0	39,802	3,863,139	30.00
31.00 03100	INTENSIVE CARE UNIT	1,674	0	1,674	988,148	31.00
43.00 04300	NURSERY	1,955	0	1,955	438,497	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	17,582	0	17,582	1,843,118	50.00
51.00 05100	RECOVERY ROOM	1,375	0	1,375	291,130	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	515,521	52.00
53.00 05300	ANESTHESIOLOGY	130	0	130	1,123,859	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,841	0	10,841	2,577,682	54.00
54.01 03630	ULTRA SOUND	0	0	0	101,329	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	483	0	483	66,736	54.02
55.00 03480	ONCOLOGY	12,370	0	12,370	1,209,102	55.00
57.00 05700	CT SCAN	895	0	895	204,567	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,080	0	1,080	126,251	58.00
59.00 05900	CARDIAC CATHETERIZATION	854	0	854	150,466	59.00
60.00 06000	LABORATORY	6,239	0	6,239	1,310,271	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	279	0	279	0	62.00
65.00 06500	RESPIRATORY THERAPY	1,197	0	1,197	593,450	65.00
66.00 06600	PHYSICAL THERAPY	14,157	0	14,157	1,661,478	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01 03610	SLEEP LAB	839	0	839	133,708	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
71.01 07101	IV SOLUTIONS	0	0	0	0	71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03140	CARDIOLOGY	6,047	0	6,047	425,277	76.00
76.97 07697	CARDIAC REHABILITATION	703	0	703	69,315	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	760	0	760	124,155	90.00
91.00 09100	EMERGENCY	13,879	0	13,879	1,552,785	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	4,732	0	4,732	1,410,886	95.00
101.00 10100	HOME HEALTH AGENCY	0	2,748	2,748	919,060	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	744	744	55,293	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	244,962	3,492	248,454	31,633,240	-16,408,226
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01 07951	MOB	47,316	0	47,316	1,650,651	194.01
194.02 07952	PHYSICIAN CLINICS	34,709	0	34,709	5,074,390	194.02
194.03 07953	PHYS PRAC BUS OFC	989	0	989	641,369	194.03
194.04 07954	MOB - MAIN CAMPUS	0	0	0	334,867	194.04
194.05 07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	194.05
194.06 07956	KDH - MC FAMILY PRACTICE	43,146	0	43,146	4,127,276	194.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
	1.00	1.01	2.00			
194.07 07957 KDH - MC ORTHOPEDICS	0	0	0	3,891,036	0	194.07
194.08 07958 KDH - MC GENERAL SURGERY	0	0	0	1,196,562	0	194.08
194.09 07959 KDH - MC ENT	0	0	0	696,330	0	194.09
194.10 07960 KDH - MC UROLOGY	0	0	0	103,868	0	194.10
194.11 07961 KDH - MC OB/GYN	0	0	0	1,728,065	0	194.11
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)	12,809,336	7,897	0	11,939,556		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	34.515162	2.261455	0.000000	0.233753		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)				0.000000		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: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet B-1	
Date/Time Prepared: 5/23/2018 1:12 pm							
Cost Center	Description	ADMINISTRATIVE & GENERAL (ACCU. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	92,566,762				5.00
7.00	00700	OPERATION OF PLANT	4,445,062	290,194			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	402,586	1,906	443,655		8.00
9.00	00900	HOUSEKEEPING	1,372,629	3,341	0	50,743	9.00
10.00	01000	DIETARY	1,042,173	6,293	0	0	52,920
11.00	01100	CAFETERIA	113,512	2,545	0	0	0
13.00	01300	NURSING ADMINISTRATION	569,430	2,234	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	204,813	3,096	0	498	0
15.00	01500	PHARMACY	1,433,428	2,301	0	871	0
16.00	01600	MEDICAL RECORDS & LIBRARY	871,984	292	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	RADIOLOGY SCHOOL	139,347	661	0	72	0
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	6,224,268	39,802	140,158	23,826	49,477
31.00	03100	INTENSIVE CARE UNIT	1,283,230	1,674	0	1,248	3,443
43.00	04300	NURSERY	621,875	1,955	7,362	210	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,550,291	17,582	89,069	5,344	0
51.00	05100	RECOVERY ROOM	216,433	1,375	11,097	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	651,781	0	8,655	703	0
53.00	05300	ANESTHESIOLOGY	167,789	130	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,426,393	10,841	27,600	1,610	0
54.01	03630	ULTRA SOUND	144,755	0	3,082	305	0
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	305,809	483	1,905	103	0
55.00	03480	ONCOLOGY	2,034,528	12,370	12,622	2,341	0
57.00	05700	CT SCAN	562,489	895	13,548	201	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	324,931	1,080	3,044	165	0
59.00	05900	CARDIAC CATHETERIZATION	224,501	854	0	423	0
60.00	06000	LABORATORY	3,440,840	6,239	0	1,408	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	304,243	279	0	0	0
65.00	06500	RESPIRATORY THERAPY	791,548	1,197	0	0	0
66.00	06600	PHYSICAL THERAPY	2,628,117	14,157	26,241	610	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03610	SLEEP LAB	267,476	839	1,765	576	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,501,663	0	0	0	0
71.01	07101	IV SOLUTIONS	110,676	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,537,480	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	8,182,618	0	0	0	0
76.00	03140	CARDIOLOGY	817,315	6,047	14,917	214	0
76.97	07697	CARDIAC REHABILITATION	116,545	703	0	244	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	180,270	760	8	261	0
91.00	09100	EMERGENCY	2,694,642	13,879	65,479	3,535	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	2,051,232	4,732	10,271	0	0
101.00	10100	HOME HEALTH AGENCY	1,235,259	2,748	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	135,546	744	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,329,507	164,034	436,823	44,768	52,920
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0
194.01	07951	MOB	3,941,944	47,316	1,097	0	0
194.02	07952	PHYSICIAN CLINICS	8,887,216	34,709	2,345	0	0
194.03	07953	PHYS PRAC BUS OFC	1,575,750	989	0	0	0
194.04	07954	MOB - MAIN CAMPUS	417,320	0	0	5,975	0
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	0	0
194.06	07956	KDH - MC FAMILY PRACTICE	6,641,877	43,146	110	0	0
194.07	07957	KDH - MC ORTHOPEDICS	4,865,781	0	784	0	0
194.08	07958	KDH - MC GENERAL SURGERY	1,721,447	0	664	0	0
194.09	07959	KDH - MC ENT	746,557	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
194.10	07960 KDH - MC UROLOGY	726,272	0	0	0	0	194.10
194.11	07961 KDH - MC OB/GYN	2,713,091	0	1,832	0	0	194.11
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)	16,408,226	5,232,985	508,318	1,676,185	1,340,387	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.177258	18.032713	1.145751	33.032832	25.328553	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,494,679	1,490,865	82,079	154,643	266,362	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.016147	5.137477	0.185006	3.047573	5.033296	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: 15-0069

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	771,699					11.00
13.00	01300	0	363,824				13.00
14.00	01400	5,590	0	9,338,171			14.00
15.00	01500	20,895	0	22,123	100		15.00
16.00	01600	24,655	0	7,456	0	283,852,461	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	4,154	0	1,047	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	158,925	158,925	136,001	0	9,893,895	30.00
31.00	03100	56,318	56,318	498	0	2,622,289	31.00
43.00	04300	13,737	13,737	0	0	1,411,072	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	46,436	46,436	4,767,809	0	28,807,802	50.00
51.00	05100	8,772	8,772	3,242	0	5,955,982	51.00
52.00	05200	16,151	16,151	0	0	1,617,375	52.00
53.00	05300	6,215	0	13,559	0	6,208,131	53.00
54.00	05400	50,475	0	58,091	0	6,900,108	54.00
54.01	03630	2,686	0	14,129	0	1,767,993	54.01
54.02	03450	2,493	0	2,137	0	5,459,702	54.02
55.00	03480	28,572	0	14,216	0	6,550,376	55.00
57.00	05700	7,909	0	119,040	0	14,802,692	57.00
58.00	05800	3,862	0	16,264	0	3,880,563	58.00
59.00	05900	4,863	0	3,790	0	1,892,584	59.00
60.00	06000	64,086	0	36,677	0	28,421,223	60.00
62.00	06200	0	0	0	0	1,961,390	62.00
65.00	06500	22,980	0	37,424	0	7,324,068	65.00
66.00	06600	55,997	0	9,679	0	11,043,177	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03610	3,664	0	117	0	1,708,227	69.01
71.00	07100	0	0	3,501,834	0	11,658,522	71.00
71.01	07101	0	0	110,676	0	2,449,919	71.01
72.00	07200	0	0	0	0	18,735,903	72.00
73.00	07300	0	0	0	100	61,832,039	73.00
76.00	03140	17,711	0	4,609	0	10,298,129	76.00
76.97	07697	3,088	0	329	0	615,693	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	3,496	0	545	0	152,327	90.00
91.00	09100	63,485	63,485	36,663	0	25,242,147	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	74,484	0	10,220	0	4,639,133	95.00
101.00	10100	0	0	23,895	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00		771,699	363,824	8,952,070	100	283,852,461	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	27,795	0	0	194.01
194.02	07952	0	0	92,686	0	0	194.02
194.03	07953	0	0	12,511	0	0	194.03
194.04	07954	0	0	13,927	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	21,768	0	0	194.06
194.07	07957	0	0	106,674	0	0	194.07
194.08	07958	0	0	61,520	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
194.09	07959 KDH - MC ENT	0	0	4,490	0	0	194.09
194.10	07960 KDH - MC UROLOGY	0	0	20,073	0	0	194.10
194.11	07961 KDH - MC OB/GYN	0	0	24,657	0	0	194.11
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)	179,526	710,651	314,697	1,763,387	1,037,803	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.232637	1.953282	0.033700	17,633.870000	0.003656	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	102,749	97,779	128,248	119,803	28,661	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.117678	0.268754	0.013734	1,198.030000	0.000101	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: 15-0069

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)	HUB SITE - 3RD YEAR MED STUDENTS (ASSIGNED TIME)	
		17.00	19.00	23.00	23.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-BLDG & FIXT HHA/HO				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
23.00	02300	RADIOLOGY SCHOOL	0	1,000		23.00
23.01	02301	HUB SITE - 3RD YEAR MED STUDENTS	0		0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,000	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	54.02
55.00	03480	ONCOLOGY	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	03610	SLEEP LAB	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
71.01	07101	IV SOLUTIONS	0	0	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1,000	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.00
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07951	MOB	0	0	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	194.02
194.03	07953	PHYS PRAC BUS OFC	0	0	0	194.03
194.04	07954	MOB - MAIN CAMPUS	0	0	0	194.04
194.05	07955	ONCOLOGY - NONREIMBURSABLE	0	0	0	194.05
194.06	07956	KDH - MC FAMILY PRACTICE	0	0	0	194.06
194.07	07957	KDH - MC ORTHOPEDICS	0	0	0	194.07
194.08	07958	KDH - MC GENERAL SURGERY	0	0	0	194.08



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet B-1

Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)	HUB SITE - 3RD YEAR MED STUDENTS (ASSIGNED TIME)		
		17.00	19.00	23.00	23.01		
194.09	07959 KDH - MC ENT	0	0	0	0		194.09
194.10	07960 KDH - MC UROLOGY	0	0	0	0		194.10
194.11	07961 KDH - MC OB/GYN	0	0	0	0		194.11
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)	0	0	179,346	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	179.346000	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	29,183	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	29.183000	0.000000		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: 15-0069

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

		Title XVIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	10,634,268		10,634,268	0	10,634,268	30.00
31.00	03100	INTENSIVE CARE UNIT	1,802,022		1,802,022	0	1,802,022	31.00
43.00	04300	NURSERY	817,920		817,920	0	817,920	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	5,142,740		5,142,740	0	5,142,740	50.00
51.00	05100	RECOVERY ROOM	333,365		333,365	0	333,365	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	841,669		841,669	0	841,669	52.00
53.00	05300	ANESTHESIOLOGY	224,475		224,475	0	224,475	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,355,063		3,355,063	0	3,355,063	54.00
54.01	03630	ULTRA SOUND	191,585		191,585	0	191,585	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	394,924		394,924	0	394,924	54.02
55.00	03480	ONCOLOGY	2,741,095		2,741,095	0	2,741,095	55.00
57.00	05700	CT SCAN	760,468		760,468	0	760,468	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	426,574		426,574	0	426,574	58.00
59.00	05900	CARDIAC CATHETERIZATION	301,847		301,847	0	301,847	59.00
60.00	06000	LABORATORY	4,329,825		4,329,825	0	4,329,825	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	370,375		370,375	0	370,375	62.00
65.00	06500	RESPIRATORY THERAPY	986,825	0	986,825	0	986,825	65.00
66.00	06600	PHYSICAL THERAPY	3,453,204	0	3,453,204	0	3,453,204	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03610	SLEEP LAB	358,167		358,167	0	358,167	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,282,997		4,282,997	0	4,282,997	71.00
71.01	07101	IV SOLUTIONS	142,981		142,981	0	142,981	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,410,283		5,410,283	0	5,410,283	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,622,536		11,622,536	0	11,622,536	73.00
76.00	03140	CARDIOLOGY	1,137,320		1,137,320	0	1,137,320	76.00
76.97	07697	CARDIAC REHABILITATION	160,921		160,921	0	160,921	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	235,948		235,948	0	235,948	90.00
91.00	09100	EMERGENCY	3,846,653		3,846,653	167,684	4,014,337	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,048,163		2,048,163		2,048,163	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	2,546,561		2,546,561	277	2,546,838	95.00
101.00	10100	HOME HEALTH AGENCY	1,504,578		1,504,578		1,504,578	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	172,989		172,989		172,989	116.00
200.00		Subtotal (see instructions)	70,578,341	0	70,578,341	167,961	70,746,302	200.00
201.00		Less Observation Beds	2,048,163		2,048,163		2,048,163	201.00
202.00		Total (see instructions)	68,530,178	0	68,530,178	167,961	68,698,139	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	9,893,895		9,893,895		30.00
31.00	03100	INTENSIVE CARE UNIT	2,622,289		2,622,289		31.00
43.00	04300	NURSERY	1,411,072		1,411,072		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	7,719,194	21,088,608	28,807,802	0.178519	50.00
51.00	05100	RECOVERY ROOM	1,798,944	4,157,038	5,955,982	0.055971	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,617,375	0	1,617,375	0.520392	52.00
53.00	05300	ANESTHESIOLOGY	2,291,436	3,916,695	6,208,131	0.036158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,306,280	5,593,828	6,900,108	0.486233	54.00
54.01	03630	ULTRA SOUND	223,125	1,544,868	1,767,993	0.108363	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	346,476	5,113,226	5,459,702	0.072334	54.02
55.00	03480	ONCOLOGY	100,690	6,449,686	6,550,376	0.418464	55.00
57.00	05700	CT SCAN	2,300,959	12,501,733	14,802,692	0.051374	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	301,672	3,578,891	3,880,563	0.109926	58.00
59.00	05900	CARDIAC CATHETERIZATION	234,104	1,658,480	1,892,584	0.159489	59.00
60.00	06000	LABORATORY	5,116,227	23,304,996	28,421,223	0.152345	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	979,934	981,456	1,961,390	0.188833	62.00
65.00	06500	RESPIRATORY THERAPY	5,438,673	1,885,395	7,324,068	0.134737	65.00
66.00	06600	PHYSICAL THERAPY	1,516,987	9,526,190	11,043,177	0.312700	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03610	SLEEP LAB	0	1,708,227	1,708,227	0.209672	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,168,157	5,490,365	11,658,522	0.367370	71.00
71.01	07101	IV SOLUTIONS	1,334,803	1,115,116	2,449,919	0.058362	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,470,362	6,265,541	18,735,903	0.288766	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,616,401	39,215,638	61,832,039	0.187969	73.00
76.00	03140	CARDIOLOGY	2,039,241	8,258,888	10,298,129	0.110439	76.00
76.97	07697	CARDIAC REHABILITATION	969	614,724	615,693	0.261366	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	152,327	152,327	1.548957	90.00
91.00	09100	EMERGENCY	4,310,418	20,931,729	25,242,147	0.152390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	530,856	2,265,834	2,796,690	0.732353	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	6,556	4,632,577	4,639,133	0.548930	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,840,934	1,840,934		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	388,825	388,825		116.00
200.00		Subtotal (see instructions)	94,697,095	194,181,815	288,878,910		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	94,697,095	194,181,815	288,878,910		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/23/2018 1:12 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.178519		50.00
51.00	05100 RECOVERY ROOM	0.055971		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.520392		52.00
53.00	05300 ANESTHESIOLOGY	0.036158		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.486233		54.00
54.01	03630 ULTRA SOUND	0.108363		54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.072334		54.02
55.00	03480 ONCOLOGY	0.418464		55.00
57.00	05700 CT SCAN	0.051374		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.109926		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.159489		59.00
60.00	06000 LABORATORY	0.152345		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.188833		62.00
65.00	06500 RESPIRATORY THERAPY	0.134737		65.00
66.00	06600 PHYSICAL THERAPY	0.312700		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	03610 SLEEP LAB	0.209672		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367370		71.00
71.01	07101 IV SOLUTIONS	0.058362		71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.288766		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.187969		73.00
76.00	03140 RADIOLOGY	0.110439		76.00
76.97	07697 CARDIAC REHABILITATION	0.261366		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	1.548957		90.00
91.00	09100 EMERGENCY	0.159033		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.732353		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.548990		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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: 15-0069

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	10,634,268		10,634,268	0	10,634,268
31.00	03100 INTENSIVE CARE UNIT	1,802,022		1,802,022	0	1,802,022
43.00	04300 NURSERY	817,920		817,920	0	817,920
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	5,142,740		5,142,740	0	5,142,740
51.00	05100 RECOVERY ROOM	333,365		333,365	0	333,365
52.00	05200 DELIVERY ROOM & LABOR ROOM	841,669		841,669	0	841,669
53.00	05300 ANESTHESIOLOGY	224,475		224,475	0	224,475
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,355,063		3,355,063	0	3,355,063
54.01	03630 ULTRA SOUND	191,585		191,585	0	191,585
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	394,924		394,924	0	394,924
55.00	03480 ONCOLOGY	2,741,095		2,741,095	0	2,741,095
57.00	05700 CT SCAN	760,468		760,468	0	760,468
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	426,574		426,574	0	426,574
59.00	05900 CARDIAC CATHETERIZATION	301,847		301,847	0	301,847
60.00	06000 LABORATORY	4,329,825		4,329,825	0	4,329,825
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	370,375		370,375	0	370,375
65.00	06500 RESPIRATORY THERAPY	986,825	0	986,825	0	986,825
66.00	06600 PHYSICAL THERAPY	3,453,204	0	3,453,204	0	3,453,204
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0
69.01	03610 SLEEP LAB	358,167		358,167	0	358,167
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,282,997		4,282,997	0	4,282,997
71.01	07101 IV SOLUTIONS	142,981		142,981	0	142,981
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5,410,283		5,410,283	0	5,410,283
73.00	07300 DRUGS CHARGED TO PATIENTS	11,622,536		11,622,536	0	11,622,536
76.00	03140 RADIOLOGY	1,137,320		1,137,320	0	1,137,320
76.97	07697 CARDIAC REHABILITATION	160,921		160,921	0	160,921
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	235,948		235,948	0	235,948
91.00	09100 EMERGENCY	3,846,653		3,846,653	167,684	4,014,337
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,048,163		2,048,163		2,048,163
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	2,546,561		2,546,561	277	2,546,838
101.00	10100 HOME HEALTH AGENCY	1,504,578		1,504,578		1,504,578
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE	172,989		172,989		172,989
200.00	Subtotal (see instructions)	70,578,341	0	70,578,341	167,961	70,746,302
201.00	Less Observation Beds	2,048,163		2,048,163		2,048,163
202.00	Total (see instructions)	68,530,178	0	68,530,178	167,961	68,698,139

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	9,893,895		9,893,895		30.00
31.00	03100	INTENSIVE CARE UNIT	2,622,289		2,622,289		31.00
43.00	04300	NURSERY	1,411,072		1,411,072		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	7,719,194	21,088,608	28,807,802	0.178519	50.00
51.00	05100	RECOVERY ROOM	1,798,944	4,157,038	5,955,982	0.055971	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,617,375	0	1,617,375	0.520392	52.00
53.00	05300	ANESTHESIOLOGY	2,291,436	3,916,695	6,208,131	0.036158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,306,280	5,593,828	6,900,108	0.486233	54.00
54.01	03630	ULTRA SOUND	223,125	1,544,868	1,767,993	0.108363	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	346,476	5,113,226	5,459,702	0.072334	54.02
55.00	03480	ONCOLOGY	100,690	6,449,686	6,550,376	0.418464	55.00
57.00	05700	CT SCAN	2,300,959	12,501,733	14,802,692	0.051374	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	301,672	3,578,891	3,880,563	0.109926	58.00
59.00	05900	CARDIAC CATHETERIZATION	234,104	1,658,480	1,892,584	0.159489	59.00
60.00	06000	LABORATORY	5,116,227	23,304,996	28,421,223	0.152345	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	979,934	981,456	1,961,390	0.188833	62.00
65.00	06500	RESPIRATORY THERAPY	5,438,673	1,885,395	7,324,068	0.134737	65.00
66.00	06600	PHYSICAL THERAPY	1,516,987	9,526,190	11,043,177	0.312700	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03610	SLEEP LAB	0	1,708,227	1,708,227	0.209672	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,168,157	5,490,365	11,658,522	0.367370	71.00
71.01	07101	IV SOLUTIONS	1,334,803	1,115,116	2,449,919	0.058362	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,470,362	6,265,541	18,735,903	0.288766	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,616,401	39,215,638	61,832,039	0.187969	73.00
76.00	03140	CARDIOLOGY	2,039,241	8,258,888	10,298,129	0.110439	76.00
76.97	07697	CARDIAC REHABILITATION	969	614,724	615,693	0.261366	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	152,327	152,327	1.548957	90.00
91.00	09100	EMERGENCY	4,310,418	20,931,729	25,242,147	0.152390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	530,856	2,265,834	2,796,690	0.732353	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	6,556	4,632,577	4,639,133	0.548930	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,840,934	1,840,934		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	388,825	388,825		116.00
200.00		Subtotal (see instructions)	94,697,095	194,181,815	288,878,910		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	94,697,095	194,181,815	288,878,910		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	03630 ULTRA SOUND	0.000000			54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000			54.02
55.00	03480 ONCOLOGY	0.000000			55.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
69.01	03610 SLEEP LAB	0.000000			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
71.01	07101 IV SOLUTIONS	0.000000			71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03140 RADIOLOGY	0.000000			76.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
101.00	10100 HOME HEALTH AGENCY				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
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: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 5/23/2018 1:12 pm	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,090,615	0	2,090,615	12,705	164.55	30.00
31.00	INTENSIVE CARE UNIT	130,266		130,266	1,248	104.38	31.00
43.00	NURSERY	95,016		95,016	1,127	84.31	43.00
200.00	Total (lines 30 through 199)	2,315,897		2,315,897	15,080		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	6,199	1,020,045				
31.00	INTENSIVE CARE UNIT	771	80,477				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	6,970	1,100,522				



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/23/2018 1:12 pm
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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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	873,596	28,807,802	0.030325	3,729,557	113,099	50.00
51.00	05100 RECOVERY ROOM	64,107	5,955,982	0.010763	1,009,340	10,864	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	20,672	1,617,375	0.012781	7,325	94	52.00
53.00	05300 ANESTHESIOLOGY	9,408	6,208,131	0.001515	824,515	1,249	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	486,501	6,900,108	0.070506	947,566	66,809	54.00
54.01	03630 ULTRA SOUND	4,526	1,767,993	0.002560	127,114	325	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	25,629	5,459,702	0.004694	255,542	1,200	54.02
55.00	03480 ONCOLOGY	537,044	6,550,376	0.081987	65,890	5,402	55.00
57.00	05700 CT SCAN	51,752	14,802,692	0.003496	1,665,363	5,822	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	50,206	3,880,563	0.012938	157,844	2,042	58.00
59.00	05900 CARDIAC CATHETERIZATION	39,592	1,892,584	0.020920	137,022	2,867	59.00
60.00	06000 LABORATORY	318,160	28,421,223	0.011194	3,471,381	38,859	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	16,174	1,961,390	0.008246	735,229	6,063	62.00
65.00	06500 RESPIRATORY THERAPY	64,204	7,324,068	0.008766	3,929,230	34,444	65.00
66.00	06600 PHYSICAL THERAPY	618,350	11,043,177	0.055994	1,029,076	57,622	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03610 SLEEP LAB	40,275	1,708,227	0.023577	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	105,813	11,658,522	0.009076	3,295,827	29,913	71.00
71.01	07101 IV SOLUTIONS	3,554	2,449,919	0.001451	769,915	1,117	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	75,159	18,735,903	0.004011	7,239,165	29,036	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	258,164	61,832,039	0.004175	13,271,491	55,408	73.00
76.00	03140 RADIOLOGY	259,575	10,298,129	0.025206	1,458,108	36,753	76.00
76.97	07697 CARDIAC REHABILITATION	30,932	615,693	0.050239	414	21	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	34,276	152,327	0.225016	0	0	90.00
91.00	09100 EMERGENCY	644,322	25,242,147	0.025526	2,791,434	71,254	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	402,652	2,796,690	0.143974	370,548	53,349	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	5,034,643	268,082,762		47,288,896	623,612	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/23/2018 1:12 pm
Title XVIII		Hospital	PPS

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	12,705	0.00	6,199	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,248	0.00	771	31.00	
43.00	04300	NURSERY		0	1,127	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	15,080		6,970	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 1:12 pm
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Cost Center Description		Title XVIII						
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	PPS	
		1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00	
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	179,346	54.00	
54.01	03630 ULTRA SOUND	0	0	0	0	0	54.01	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.02	
55.00	03480 ONCOLOGY	0	0	0	0	0	55.00	
57.00	05700 CT SCAN	0	0	0	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000 LABORATORY	0	0	0	0	0	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
69.01	03610 SLEEP LAB	0	0	0	0	0	69.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
71.01	07101 IV SOLUTIONS	0	0	0	0	0	71.01	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	03140 RADIOLOGY	0	0	0	0	0	76.00	
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000 CLINIC	0	0	0	0	0	90.00	
91.00	09100 EMERGENCY	0	0	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00	
200.00	Total (lines 50 through 199)	0	0	0	0	179,346	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 1:12 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	28,807,802	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,955,982	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,617,375	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,208,131	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	179,346	179,346	6,900,108	0.025992	54.00
54.01	03630	ULTRA SOUND	0	0	0	1,767,993	0.000000	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	5,459,702	0.000000	54.02
55.00	03480	ONCOLOGY	0	0	0	6,550,376	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	14,802,692	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,880,563	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,892,584	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	28,421,223	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,961,390	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,324,068	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,043,177	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03610	SLEEP LAB	0	0	0	1,708,227	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,658,522	0.000000	71.00
71.01	07101	IV SOLUTIONS	0	0	0	2,449,919	0.000000	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,735,903	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,832,039	0.000000	73.00
76.00	03140	CARDIOLOGY	0	0	0	10,298,129	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	615,693	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	152,327	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	25,242,147	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,796,690	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	179,346	179,346	268,082,762		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 1:12 pm
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Cost Center Description		Title XVIII				Hospital	
		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)	PPS
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	3,729,557	0	7,220,891	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	1,009,340	0	1,224,344	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	7,325	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	824,515	0	980,478	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.025992	947,566	24,629	1,627,960	42,314	54.00
54.01	03630 ULTRA SOUND	0.000000	127,114	0	373,366	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	255,542	0	2,260,265	0	54.02
55.00	03480 ONCOLOGY	0.000000	65,890	0	3,258,027	0	55.00
57.00	05700 CT SCAN	0.000000	1,665,363	0	4,263,711	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	157,844	0	1,252,069	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	137,022	0	728,668	0	59.00
60.00	06000 LABORATORY	0.000000	3,471,381	0	2,876,180	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	735,229	0	293,143	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	3,929,230	0	497,619	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,029,076	0	40,854	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03610 SLEEP LAB	0.000000	0	0	717,101	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,295,827	0	1,217,578	0	71.00
71.01	07101 IV SOLUTIONS	0.000000	769,915	0	317,702	0	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,239,165	0	1,487,763	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	13,271,491	0	17,653,815	0	73.00
76.00	03140 RADIOLOGY	0.000000	1,458,108	0	3,650,189	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	414	0	331,166	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	15,277	0	90.00
91.00	09100 EMERGENCY	0.000000	2,791,434	0	5,214,371	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	370,548	0	768,867	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		47,288,896	24,629	58,271,404	42,314	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 1:12 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.178519	7,220,891	0	0	1,289,066	50.00
51.00	05100	RECOVERY ROOM	0.055971	1,224,344	0	0	68,528	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.520392	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.036158	980,478	0	0	35,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.486233	1,627,960	0	0	791,568	54.00
54.01	03630	ULTRA SOUND	0.108363	373,366	0	0	40,459	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.072334	2,260,265	0	0	163,494	54.02
55.00	03480	ONCOLOGY	0.418464	3,258,027	0	0	1,363,367	55.00
57.00	05700	CT SCAN	0.051374	4,263,711	0	0	219,044	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.109926	1,252,069	0	0	137,635	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.159489	728,668	0	0	116,215	59.00
60.00	06000	LABORATORY	0.152345	2,876,180	0	0	438,172	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.188833	293,143	0	0	55,355	62.00
65.00	06500	RESPIRATORY THERAPY	0.134737	497,619	0	0	67,048	65.00
66.00	06600	PHYSICAL THERAPY	0.312700	40,854	0	0	12,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03610	SLEEP LAB	0.209672	717,101	0	0	150,356	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367370	1,217,578	0	0	447,302	71.00
71.01	07101	IV SOLUTIONS	0.058362	317,702	0	0	18,542	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.288766	1,487,763	0	0	429,615	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187969	17,653,815	0	16,270	3,318,370	73.00
76.00	03140	CARDIOLOGY	0.110439	3,650,189	0	0	403,123	76.00
76.97	07697	CARDIAC REHABILITATION	0.261366	331,166	0	0	86,556	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	1.548957	15,277	0	0	23,663	90.00
91.00	09100	EMERGENCY	0.152390	5,214,371	0	0	794,618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.732353	768,867	0	0	563,082	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0.548930		0			95.00
200.00		Subtotal (see instructions)		58,271,404	0	16,270	11,033,405	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		58,271,404	0	16,270	11,033,405	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 1:12 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03630 ULTRA SOUND	0	0		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.02
55.00 03480 ONCOLOGY	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 03610 SLEEP LAB	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
71.01 07101 IV SOLUTIONS	0	0		71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3,058		73.00
76.00 03140 CARDIOLOGY	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00	Subtotal (see instructions)	0	3,058	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	3,058	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 1:12 pm
Title XIX		Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.178519	0	0	3,031,087	0
51.00 05100 RECOVERY ROOM	0.055971	0	0	1,139,157	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.520392	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.036158	0	0	830,271	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.486233	0	0	1,129,326	0
54.01 03630 ULTRA SOUND	0.108363	0	0	380,291	0
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.072334	0	0	477,578	0
55.00 03480 ONCOLOGY	0.418464	0	0	638,580	0
57.00 05700 CT SCAN	0.051374	0	0	2,314,203	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.109926	0	0	554,614	0
59.00 05900 CARDIAC CATHETERIZATION	0.159489	0	0	221,183	0
60.00 06000 LABORATORY	0.152345	0	0	4,766,692	0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.188833	0	0	64,586	0
65.00 06500 RESPIRATORY THERAPY	0.134737	0	0	381,179	0
66.00 06600 PHYSICAL THERAPY	0.312700	0	0	1,552,411	0
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
69.01 03610 SLEEP LAB	0.209672	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367370	0	0	1,034,472	0
71.01 07101 IV SOLUTIONS	0.058362	0	0	224,590	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.288766	0	0	722,830	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.187969	0	0	4,304,525	0
76.00 03140 RADIOLOGY	0.110439	0	0	1,423,236	0
76.97 07697 CARDIAC REHABILITATION	0.261366	0	0	17,317	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	1.548957	0	0	11,242	0
91.00 09100 EMERGENCY	0.152390	0	0	6,772,137	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.732353	0	0	620,519	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES	0.548930	0	0		95.00
200.00	Subtotal (see instructions)	0	0	32,612,026	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	201.00
202.00	Net Charges (line 200 - line 201)			32,612,026	0



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 1:12 pm
		Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	541,107	50.00
51.00	05100	RECOVERY ROOM	0	63,760	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	30,021	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	549,116	54.00
54.01	03630	ULTRA SOUND	0	41,209	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	34,545	54.02
55.00	03480	ONCOLOGY	0	267,223	55.00
57.00	05700	CT SCAN	0	118,890	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	60,966	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	35,276	59.00
60.00	06000	LABORATORY	0	726,182	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	12,196	62.00
65.00	06500	RESPIRATORY THERAPY	0	51,359	65.00
66.00	06600	PHYSICAL THERAPY	0	485,439	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03610	SLEEP LAB	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	380,034	71.00
71.01	07101	IV SOLUTIONS	0	13,108	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	208,729	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	809,117	73.00
76.00	03140	CARDIOLOGY	0	157,181	76.00
76.97	07697	CARDIAC REHABILITATION	0	4,526	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	17,413	90.00
91.00	09100	EMERGENCY	0	1,032,006	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	454,439	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	6,093,842	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	6,093,842	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/23/2018 1:12 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,705	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,705	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)		10,258	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)		6,199	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
<b>SWING BED ADJUSTMENT</b>				
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)		10,634,268	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)		10,634,268	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		10,634,268	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		837.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,188,625	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)		5,188,625	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/23/2018 1:12 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	1,802,022	1,248	1,443.93	771	1,113,270	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)					9,637,352	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,939,247	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)					1,100,522	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					648,241	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,748,763	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,190,484	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)					2,447	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					837.01	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,048,163	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/23/2018 1:12 pm	
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	2,090,615	10,634,268	0.196592	2,048,163	402,652	90.00
91.00	Nursing School cost	0	10,634,268	0.000000	2,048,163	0	91.00
92.00	Allied health cost	0	10,634,268	0.000000	2,048,163	0	92.00
93.00	All other Medical Education	0	10,634,268	0.000000	2,048,163	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/23/2018 1:12 pm
Cost Center Description				Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,705	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,705	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)		10,258	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)		1,345	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)		1,127	15.00
16.00	Nursery days (title V or XIX only)		232	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		10,634,268	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)		10,634,268	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		10,634,268	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		837.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,125,778	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,125,778	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/23/2018 1:12 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)	817,920	1,127	725.75	232	168,374	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,802,022	1,248	1,443.93	157	226,697	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,101,317	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,622,166	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)					2,447	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					837.01	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,048,163	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/23/2018 1:12 pm	
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	2,090,615	10,634,268	0.196592	2,048,163	402,652	90.00
91.00	Nursing School cost	0	10,634,268	0.000000	2,048,163	0	91.00
92.00	Allied health cost	0	10,634,268	0.000000	2,048,163	0	92.00
93.00	All other Medical Education	0	10,634,268	0.000000	2,048,163	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/23/2018 1:12 pm	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		6,321,201	30.00
31.00	03100	INTENSIVE CARE UNIT		1,498,971	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.178519	3,729,557	50.00
51.00	05100	RECOVERY ROOM	0.055971	1,009,340	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.520392	7,325	52.00
53.00	05300	ANESTHESIOLOGY	0.036158	824,515	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.486233	947,566	54.00
54.01	03630	ULTRA SOUND	0.108363	127,114	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.072334	255,542	54.02
55.00	03480	ONCOLOGY	0.418464	65,890	55.00
57.00	05700	CT SCAN	0.051374	1,665,363	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.109926	157,844	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.159489	137,022	59.00
60.00	06000	LABORATORY	0.152345	3,471,381	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.188833	735,229	62.00
65.00	06500	RESPIRATORY THERAPY	0.134737	3,929,230	65.00
66.00	06600	PHYSICAL THERAPY	0.312700	1,029,076	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03610	SLEEP LAB	0.209672	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367370	3,295,827	71.00
71.01	07101	IV SOLUTIONS	0.058362	769,915	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.288766	7,239,165	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187969	13,271,491	73.00
76.00	03140	CARDIOLOGY	0.110439	1,458,108	76.00
76.97	07697	CARDIAC REHABILITATION	0.261366	414	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.548957	0	90.00
91.00	09100	EMERGENCY	0.159033	2,791,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.732353	370,548	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		47,288,896	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)		47,288,896	202.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/23/2018 1:12 pm	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		1,378,050	30.00
31.00	03100	INTENSIVE CARE UNIT		305,365	31.00
43.00	04300	NURSERY		736,990	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.178519	1,045,152	186,579 50.00
51.00	05100	RECOVERY ROOM	0.055971	296,947	16,620 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.520392	732,549	381,213 52.00
53.00	05300	ANESTHESIOLOGY	0.036158	509,040	18,406 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.486233	132,782	64,563 54.00
54.01	03630	ULTRA SOUND	0.108363	35,222	3,817 54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.072334	17,369	1,256 54.02
55.00	03480	ONCOLOGY	0.418464	98	41 55.00
57.00	05700	CT SCAN	0.051374	252,808	12,988 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.109926	54,188	5,957 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.159489	13,891	2,215 59.00
60.00	06000	LABORATORY	0.152345	773,757	117,878 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.188833	54,964	10,379 62.00
65.00	06500	RESPIRATORY THERAPY	0.134737	544,415	73,353 65.00
66.00	06600	PHYSICAL THERAPY	0.312700	85,678	26,792 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0 69.00
69.01	03610	SLEEP LAB	0.209672	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367370	662,439	243,360 71.00
71.01	07101	IV SOLUTIONS	0.058362	196,892	11,491 71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.288766	568,410	164,137 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187969	3,310,127	622,201 73.00
76.00	03140	CARDIOLOGY	0.110439	205,755	22,723 76.00
76.97	07697	CARDIAC REHABILITATION	0.261366	0	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.548957	0	0 90.00
91.00	09100	EMERGENCY	0.152390	512,850	78,153 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.732353	50,789	37,195 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,056,122	2,101,317 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		10,056,122	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/23/2018 1:12 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		9,229,177	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,337,245	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)		133,102	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		2,060,063	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		81.30	4.00
<b>Indirect Medical Education Adjustment</b>				
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
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
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
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.09	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.55	31.00
32.00	Sum of lines 30 and 31		23.64	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.72	33.00
34.00	Disproportionate share adjustment (see instructions)		273,948	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/23/2018 1:12 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000081381	0.000109990	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	486,454	744,269	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	363,841	187,597	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	551,438		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
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 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 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 and 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)	13,524,910		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	14,223,042		48.00
				<b>Amount</b>
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		14,223,042	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,054,468	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		11,407	53.00
54.00	Special add-on payments for new technologies		0	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 instructions)		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)		24,629	58.00
59.00	Total (sum of amounts on lines 49 through 58)		15,313,546	59.00
60.00	Primary payer payments		4,745	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		15,308,801	61.00
62.00	Deductibles billed to program beneficiaries		1,652,448	62.00
63.00	Coinurance billed to program beneficiaries		22,043	63.00
64.00	Allowable bad debts (see instructions)		208,409	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		135,466	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		60,171	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,769,776	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)		0	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)		121,601	70.93
70.94	HRR adjustment amount (see instructions)		-323,196	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/23/2018 1:12 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	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)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			13,568,181	71.00
71.01	Sequestration adjustment (see instructions)			271,364	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			13,498,628	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)			-201,811	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,170,540	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
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	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)			0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>					
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
<b>Cost Reimbursement</b>					
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
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>					
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
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>					
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
<b>Comparison of PPS versus Cost Reimbursement</b>					
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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/23/2018 1:12 pm
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		Title XVIII			Hospital	PPS	
	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	9,229,177	9,229,177		9,229,177	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,337,245		3,337,245	3,337,245	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	133,102	95,374	37,728	133,102	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	2,060,063	1,489,667	570,397	2,060,064	4.00
<b>Indirect Medical Education Adjustment</b>							
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
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
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
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0872	0.0872	0.0872		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	273,948	201,196	72,752	273,948	11.00
11.01	Uncompensated care payments	36.00	551,438	363,841	187,597	551,438	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,524,910	9,889,588	3,635,322	13,524,910	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	14,223,042	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,223,042	14,223,042	0	14,223,042	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,054,468	773,982	280,486	1,054,468	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	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	<b>SUBTOTAL</b>			14,997,024	280,486	15,277,510	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/23/2018 1:12 pm
Title XVIII		Hospital	PPS

		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	1,015,100	743,880	271,220	1,015,100	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	39,368	30,102	9,266	39,368	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	1,054,468	773,982	280,486	1,054,468	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	121,601	80,936	40,665	121,601	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	-323,196	-250,110	-73,086	-323,196	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		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/23/2018 1:12 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		3,058	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,991,091	2.00
3.00	OPPS payments		12,087,526	3.00
4.00	Outlier payment (see instructions)		29,351	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		42,314	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,058	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		16,270	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)		16,270	14.00
<b>Customary charges</b>				
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 charge basis 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)		16,270	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		13,212	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)		3,058	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)		12,159,191	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,447,442	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)		9,714,807	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)		9,714,807	30.00
31.00	Primary payer payments		3,838	31.00
32.00	Subtotal (line 30 minus line 31)		9,710,969	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		394,418	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		256,372	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		258,742	36.00
37.00	Subtotal (see instructions)		9,967,341	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-61	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)		9,967,402	40.00
40.01	Sequestration adjustment (see instructions)		199,348	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		9,763,359	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		4,695	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		223,161	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0069		Period: From 01/01/2017 To 12/31/2017		Worksheet E-1 Part I Date/Time Prepared: 5/23/2018 1:12 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		13,498,628		9,763,359	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)		13,498,628		9,763,359	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		4,695	6.01	
6.02	SETTLEMENT TO PROGRAM		201,811		0	6.02	
7.00	Total Medicare program liability (see instructions)		13,296,817		9,768,054	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: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/23/2018 1:12 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 IPSS & 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: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2018 1:12 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		3,622,166		1.00
2.00	Medical and other services			6,093,842	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,622,166	6,093,842	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,622,166	6,093,842	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		10,056,122	32,612,026	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		10,056,122	32,612,026	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		10,056,122	32,612,026	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		6,433,956	26,518,184	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		3,622,166	6,093,842	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		3,622,166	6,093,842	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3,622,166	6,093,842	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		3,622,166	6,093,842	36.00
37.00	ZERO SETTLEMENT		-3,622,166	-6,093,842	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-0069

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

Worksheet G  
Date/Time Prepared:  
5/23/2018 1:12 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	16,303,840	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,370,400	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,497,096	0	0	0	7.00
8.00	Prepaid expenses	2,917,927	0	0	0	8.00
9.00	Other current assets	210,357	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)	32,299,620	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	4,045,918	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	118,000,503	0	0	0	15.00
16.00	Accumulated depreciation	-30,916,975	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	1,253,908	0	0	0	21.00
22.00	Accumulated depreciation	-1,090,585	0	0	0	22.00
23.00	Major movable equipment	62,399,767	0	0	0	23.00
24.00	Accumulated depreciation	-46,686,777	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	107,005,759	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	137,600,992	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	137,600,992	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	276,906,371	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,035,338	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	461,761	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	11,809,545	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,306,644	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	92,316,785	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,328,270	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	93,645,055	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	107,951,699	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	168,954,672				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)	168,954,672	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	276,906,371	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0069

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

Worksheet G-1

Date/Time Prepared:  
5/23/2018 1:12 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		148,855,645		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		20,099,027				2.00
3.00	Total (sum of line 1 and line 2)		168,954,672		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)		168,954,672		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)		168,954,672		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: 15-0069

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	13,088,777		13,088,777	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	13,088,777		13,088,777	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,422,631		2,422,631	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)	2,422,631		2,422,631	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,511,408		15,511,408	17.00
18.00	Ancillary services	80,749,123	279,110,510	359,859,633	18.00
19.00	Outpatient services	0	0	0	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		1,841,795	1,841,795	22.00
23.00	AMBULANCE SERVICES	6,556	4,657,275	4,663,831	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	388,825	388,825	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	96,267,087	285,998,405	382,265,492	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		123,624,971		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		123,624,971		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/23/2018 1:12 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	382,265,492	1.00
2.00	Less contractual allowances and discounts on patients' accounts	255,270,324	2.00
3.00	Net patient revenues (line 1 minus line 2)	126,995,168	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	123,624,971	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,370,197	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	49,724	6.00
7.00	Income from investments	2,666,798	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	366,454	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	171	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	127	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	49,055	23.00
24.00	OTHER OPERATING INCOME	13,596,501	24.00
24.01	GAIN/LOSS ON SALE	0	24.01
24.02	OTHER NONOPERATING REVENUE	0	24.02
25.00	Total other income (sum of lines 6-24)	16,728,830	25.00
26.00	Total (line 5 plus line 25)	20,099,027	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)	20,099,027	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet H

HHA CCN: 15-7141

To 12/31/2017

Date/Time Prepared: 5/23/2018 1:12 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00	918,972	88	946	0	10,000	930,006	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	0	0	33,236	0	0	33,236	6.00
7.00	0	0	27,362	0	0	27,362	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	0	0	0	0	0	0	10.00
11.00	0	0	3,727	0	0	3,727	11.00
12.00	0	0	0	0	19,179	19,179	12.00
13.00	0	0	0	0	702	702	13.00
14.00	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
23.50	0	0	0	0	0	0	23.50
24.00	918,972	88	65,271	0	29,881	1,014,212	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	-328,875	601,131	0	601,131			5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	26,025	59,261	0	59,261			6.00
7.00	215,391	242,753	0	242,753			7.00
8.00	58,464	58,464	0	58,464			8.00
9.00	4,953	4,953	0	4,953			9.00
10.00	0	0	0	0			10.00
11.00	24,042	27,769	0	27,769			11.00
12.00	0	19,179	0	19,179			12.00
13.00	0	702	0	702			13.00
14.00	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
23.50	0	0	0	0			23.50
24.00	0	1,014,212	0	1,014,212			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2017 To 12/31/2017	Worksheet H-1 Part I Date/Time Prepared: 5/23/2018 1:12 pm			
			Home Health Agency I	PPS			
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
	0	1.00	2.00	3.00	4.00	4A.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	601,131	0	0	0	601,131	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	59,261	0	0	0	59,261	6.00
7.00	Physical Therapy	242,753	0	0	0	242,753	7.00
8.00	Occupational Therapy	58,464	0	0	0	58,464	8.00
9.00	Speech Pathology	4,953	0	0	0	4,953	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	27,769	0	0	0	27,769	11.00
12.00	Supplies (see instructions)	19,179	0	0	0	19,179	12.00
13.00	Drugs	702	0	0	0	702	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,014,212	0	0	0	1,014,212	24.00
	Administrative & General		Total (cols. 4A + 5)				
	5.00		6.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	601,131					5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	86,239	145,500				6.00
7.00	Physical Therapy	353,262	596,015				7.00
8.00	Occupational Therapy	85,079	143,543				8.00
9.00	Speech Pathology	7,208	12,161				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	40,411	68,180				11.00
12.00	Supplies (see instructions)	27,910	47,089				12.00
13.00	Drugs	1,022	1,724				13.00
14.00	DME	0	0				14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		1,014,212				24.00



COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet H-1

HHA CCN: 15-7141

To 12/31/2017

Part II  
Date/Time Prepared:  
5/23/2018 1:12 pm

Home Health  
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-601,131	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	59,261	6.00
7.00	Physical Therapy	0	0	0	0	242,753	7.00
8.00	Occupational Therapy	0	0	0	0	58,464	8.00
9.00	Speech Pathology	0	0	0	0	4,953	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	27,769	11.00
12.00	Supplies (see instructions)	0	0	0	0	19,179	12.00
13.00	Drugs	0	0	0	0	702	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-601,131	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	601,131	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	1.455238	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet H-2

HHA CCN: 15-7141

To 12/31/2017

Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Home Health  
Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP			
		1.00	1.01	2.00			
1.00 Administrative and General	0	0	6,214	0	214,833	221,047	1.00
2.00 Skilled Nursing Care	145,500	0	0	0	0	145,500	2.00
3.00 Physical Therapy	596,015	0	0	0	0	596,015	3.00
4.00 Occupational Therapy	143,543	0	0	0	0	143,543	4.00
5.00 Speech Pathology	12,161	0	0	0	0	12,161	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	68,180	0	0	0	0	68,180	7.00
8.00 Supplies (see instructions)	47,089	0	0	0	0	47,089	8.00
9.00 Drugs	1,724	0	0	0	0	1,724	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	1,014,212	0	6,214	0	214,833	1,235,259	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00
Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	5.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	39,182	49,554	0	0	0	0	1.00
2.00 Skilled Nursing Care	25,791	0	0	0	0	0	2.00
3.00 Physical Therapy	105,649	0	0	0	0	0	3.00
4.00 Occupational Therapy	25,444	0	0	0	0	0	4.00
5.00 Speech Pathology	2,156	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	12,085	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	8,347	0	0	0	0	0	8.00
9.00 Drugs	306	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	218,960	49,554	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet H-2

HHA CCN: 15-7141

To 12/31/2017

Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Home Health Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		13.00	14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	805	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	805	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		RADIOLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		23.00	23.01	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	0	309,783	0	309,783	0	1.00
2.00	Skilled Nursing Care	0	0	171,291	0	171,291	44,412	2.00
3.00	Physical Therapy	0	0	701,664	0	701,664	181,926	3.00
4.00	Occupational Therapy	0	0	168,987	0	168,987	43,814	4.00
5.00	Speech Pathology	0	0	14,317	0	14,317	3,712	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	80,265	0	80,265	20,811	7.00
8.00	Supplies (see instructions)	0	0	56,241	0	56,241	14,582	8.00
9.00	Drugs	0	0	2,030	0	2,030	526	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	1,504,578	0	1,504,578	309,783	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.259277	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part I Date/Time Prepared: 5/23/2018 1:12 pm PPS
			Home Health Agency I	

Cost Center Description	Total HHA Costs		
	28.00		
1.00 Administrative and General			1.00
2.00 Skilled Nursing Care	215,703		2.00
3.00 Physical Therapy	883,590		3.00
4.00 Occupational Therapy	212,801		4.00
5.00 Speech Pathology	18,029		5.00
6.00 Medical Social Services	0		6.00
7.00 Home Health Aide	101,076		7.00
8.00 Supplies (see instructions)	70,823		8.00
9.00 Drugs	2,556		9.00
10.00 DME	0		10.00
11.00 Home Dialysis Aide Services	0		11.00
12.00 Respiratory Therapy	0		12.00
13.00 Private Duty Nursing	0		13.00
14.00 Clinic	0		14.00
15.00 Health Promotion Activities	0		15.00
16.00 Day Care Program	0		16.00
17.00 Home Delivered Meals Program	0		17.00
18.00 Homemaker Service	0		18.00
19.00 All Others (specify)	0		19.00
19.50 Telemedicine	0		19.50
20.00 Total (sum of lines 1-19) (2)	1,504,578		20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part II Date/Time Prepared: 5/23/2018 1:12 pm
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		Home Health Agency I	PPS
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	1.01	2.00				
1.00 Administrative and General	0	2,748	2,748	919,060	0	221,047	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	145,500	2.00
3.00 Physical Therapy	0	0	0	0	0	596,015	3.00
4.00 Occupational Therapy	0	0	0	0	0	143,543	4.00
5.00 Speech Pathology	0	0	0	0	0	12,161	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	68,180	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	47,089	8.00
9.00 Drugs	0	0	0	0	0	1,724	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	2,748	2,748	919,060	0	1,235,259	20.00
21.00 Total cost to be allocated	0	6,214	0	214,833	0	218,960	21.00
22.00 Unit cost multiplier	0.000000	2.261281	0.000000	0.233753	0	0.177258	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NRSING HRS)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	2,748	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	2,748	0	0	0	0	0	20.00
21.00 Total cost to be allocated	49,554	0	0	0	0	0	21.00
22.00 Unit cost multiplier	18.032751	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part II Date/Time Prepared: 5/23/2018 1:12 pm
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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	RADIOLOGY SCHOOL (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	19.00	23.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	23,895	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telmedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	23,895	0	0	0	0	0	20.00
21.00	Total cost to be allocated	805	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.033689	0.000000	0.000000	0.000000	0.000000	0.000000	22.00
Cost Center Description		HUB SITE - 3RD YEAR MED STUDENTS (ASSIGNED TIME)						
		23.01						
1.00	Administrative and General	0						1.00
2.00	Skilled Nursing Care	0						2.00
3.00	Physical Therapy	0						3.00
4.00	Occupational Therapy	0						4.00
5.00	Speech Pathology	0						5.00
6.00	Medical Social Services	0						6.00
7.00	Home Health Aide	0						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
19.50	Telmedicine	0						19.50
20.00	Total (sum of lines 1-19)	0						20.00
21.00	Total cost to be allocated	0						21.00
22.00	Unit cost multiplier	0.000000						22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet H-3 Part I
				HHA CCN: 15-7141		Date/Time Prepared: 5/23/2018 1:12 pm

				Title XVIII	Home Health Agency I	PPS
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	215,703		215,703	3,918	55.05	1.00
2.00	Physical Therapy	3.00	883,590	0	883,590	3,046	290.08	2.00
3.00	Occupational Therapy	4.00	212,801	0	212,801	773	275.29	3.00
4.00	Speech Pathology	5.00	18,029	0	18,029	59	305.58	4.00
5.00	Medical Social Services	6.00	0		0	3	0.00	5.00
6.00	Home Health Aide	7.00	101,076		101,076	388	260.51	6.00
7.00	Total (sum of lines 1-6)		1,431,199	0	1,431,199	8,187		7.00

		Program Visits				
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Part B		
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		31140	0	15		8.00
8.01	Skilled Nursing Care		99915	0	2,271		8.01
9.00	Physical Therapy		31140	0	24		9.00
9.01	Physical Therapy		99915	0	2,096		9.01
10.00	Occupational Therapy		31140	0	4		10.00
10.01	Occupational Therapy		99915	0	533		10.01
11.00	Speech Pathology		31140	0	0		11.00
11.01	Speech Pathology		99915	0	40		11.01
12.00	Medical Social Services		31140	0	0		12.00
12.01	Medical Social Services		99915	0	1		12.01
13.00	Home Health Aide		31140	0	19		13.00
13.01	Home Health Aide		99915	0	309		13.01
14.00	Total (sum of lines 8-13)			0	5,312		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	70,823	0	70,823	0	0.000000	15.00
16.00	Cost of Drugs	9.00	2,556	0	2,556	0	0.000000	16.00

		Program Visits				
Cost Center Description	Part A	Part B		Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,286		0	125,844	1.00
2.00	Physical Therapy	0	2,120		0	614,970	2.00
3.00	Occupational Therapy	0	537		0	147,831	3.00
4.00	Speech Pathology	0	40		0	12,223	4.00
5.00	Medical Social Services	0	1		0	0	5.00
6.00	Home Health Aide	0	328		0	85,447	6.00
7.00	Total (sum of lines 1-6)	0	5,312		0	986,315	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet H-3

HHA CCN: 15-7141

To 12/31/2017

Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Title XVIII

Home Health Agency I

PPS

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	125,844						1.00
2.00	Physical Therapy	614,970						2.00
3.00	Occupational Therapy	147,831						3.00
4.00	Speech Pathology	12,223						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	85,447						6.00
7.00	Total (sum of lines 1-6)	986,315						7.00
Cost Center Description		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00



APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2017 To 12/31/2017	Worksheet H-3 Part II Date/Time Prepared: 5/23/2018 1:12 pm
		Title XVIII	Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy	66.00	0.312700	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.367370	0	0	col. 2, line 15.00 4.00
4.01	Cost of Medical Supplies 1	71.01	0.058362	0	0	col. 2, line 15.01 4.01
5.00	Cost of Drugs	73.00	0.187969	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2017 To 12/31/2017	Worksheet H-4 Part I-II Date/Time Prepared: 5/23/2018 1:12 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
<b>Customary Charges</b>				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	902,568
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	15,583
13.00	Total PPS Reimbursement - LUPA Episodes		0	25,650
14.00	Total PPS Reimbursement - PEP Episodes		0	11,436
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	5,628
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	960,865
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	960,865
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	960,865
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	960,865
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	960,865
31.01	Sequestration adjustment (see instructions)		0	19,217
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	941,648
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0069 HHA CCN: 15-7141	Period: From 01/01/2017 To 12/31/2017	Worksheet H-5 Date/Time Prepared: 5/23/2018 1:12 pm
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		941,648	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		941,648	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		941,648	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet 0

Hospice CCN: 15-1535

To 12/31/2017

Date/Time Prepared: 5/23/2018 1:12 pm

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0
4.00	ADMINISTRATIVE & GENERAL*	55,293	4,096	59,389	-45,297	14,092
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0
11.00	MEDICAL RECORDS*	0	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	391	391	0	391
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	1,497	1,497
14.00	PHARMACY*	0	14,674	14,674	0	14,674
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
<b>DIRECT PATIENT CARE SERVICE COST CENTERS</b>						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0
26.00	PHYSICIAN SERVICES**	0	0	0	0	0
27.00	NURSE PRACTITIONER**	0	0	0	0	0
28.00	REGISTERED NURSE**	0	6,619	6,619	39,033	45,652
29.00	LPN/LVN**	0	0	0	0	0
30.00	PHYSICAL THERAPY**	0	535	535	33	568
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	0	1,188	1,188	0	1,188
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	2,060	2,060	4,734	6,794
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	36,082	36,082	0	36,082
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0
100.00	TOTAL	55,293	65,645	120,938	0	120,938

\* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet 0

Hospice CCN: 15-1535

To 12/31/2017

Date/Time Prepared: 5/23/2018 1:12 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	14,092	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	391	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	1,497	13.00
14.00	PHARMACY*	0	14,674	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
<b>DIRECT PATIENT CARE SERVICE COST CENTERS</b>				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	45,652	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	568	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	1,188	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 & HOME MAKER SERVICES**	0	6,794	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	36,082	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
<b>NONREIMBURSABLE COST CENTERS</b>				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	120,938	100.00

\* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0069 Hospice CCN: 15-1535	Period: From 01/01/2017 To 12/31/2017	Worksheet 0-2 Date/Time Prepared: 5/23/2018 1:12 pm
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
<b>DI RECT PATIENT CARE SERVICE COST CENTERS</b>						
25.00	INPATIENT CARE-CONTRACTED					25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	6,506	6,506	38,371	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	526	526	33	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	1,168	1,168	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	2,025	2,025	4,654	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	36,082	36,082	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	46,307	46,307	43,058	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS		TOTAL (col. 5 ± col. 6)	
	6.00	7.00		
<b>DI RECT PATIENT CARE SERVICE COST CENTERS</b>				
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	44,877	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	559	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	1,168	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 & HOME MAKER SERVICES	0	6,679	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	36,082	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	89,365	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

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

Provider CCN: 15-0069

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

Worksheet 0-3

Hospice CCN: 15-1535

Date/Time Prepared: 5/23/2018 1:12 pm

	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
<b>DI RECT PATIENT CARE SERVICE COST CENTERS</b>						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	64	64	375	439 28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	5	5	0	5 30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	11	11	0	11 33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	20	20	45	65 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	100	100	420	520 100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
<b>DI RECT PATIENT CARE SERVICE COST CENTERS</b>			
25.00	INPATIENT CARE-CONTRACTED	0	25.00
26.00	PHYSICIAN SERVICES	0	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	0	28.00
29.00	LPN/LVN	0	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	33.00
34.00	SPIRITUAL COUNSELING	0	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	0	520 100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

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

Provider CCN: 15-0069

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

Worksheet 0-4

Hospice CCN: 15-1535

Date/Time Prepared:  
5/23/2018 1:12 pm

	Hospice I					SUBTOTAL
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS		
	1.00	2.00	3.00	4.00	5.00	
<b>DI RECT PATIENT CARE SERVICE COST CENTERS</b>						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	49	49	287	336 28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	4	4	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	9	9	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	15	15	35	50 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	77	77	322	399 100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
<b>DI RECT PATIENT CARE SERVICE COST CENTERS</b>			
25.00	INPATIENT CARE-CONTRACTED	0	25.00
26.00	PHYSICIAN SERVICES	0	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	0	28.00
29.00	LPN/LVN	0	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	33.00
34.00	SPIRITUAL COUNSELING	0	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	0	399 100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.



COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPI CE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet 0-5

Hospice CCN: 15-1535

To 12/31/2017

Date/Time Prepared: 5/23/2018 1:12 pm

Descriptions		Hospice I			
		HOSPI CE DI RECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of col s. 1 + 2)	
		1.00	2.00	3.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	0	1,683	1,683	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	12,925	12,925	3.00
4.00	ADMINISTRATIVE & GENERAL	14,092	24,027	38,119	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	13,416	13,416	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	391		391	12.00
13.00	VOLUNTEER SERVICE COORDINATION	1,497		1,497	13.00
14.00	PHARMACY	14,674	0	14,674	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
<b>LEVEL OF CARE</b>					
50.00	HOSPI CE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPI CE ROUTINE HOME CARE	89,365		89,365	51.00
52.00	HOSPI CE INPATIENT RESPI TE CARE	520		520	52.00
53.00	HOSPI CE GENERAL INPATIENT CARE	399		399	53.00
<b>NONREIMBURSABLE COST CENTERS</b>					
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	HOSPI CE/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	120,938	52,051	172,989	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2017

Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
	0	1.00	2.00	3.00	3A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIX	1,683	1,683			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	12,925	0	0	12,925	3.00
4.00	ADMINISTRATIVE & GENERAL	38,119	1,683	0	2,337	42,139
5.00	PLANT OPERATION & MAINTENANCE	13,416	0	0	0	13,416
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0
7.00	HOUSEKEEPING	0	0	0	0	0
8.00	DIETARY	0	0	0	0	0
9.00	NURSING ADMINISTRATION	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0
11.00	MEDICAL RECORDS	0	0	0	0	0
12.00	STAFF TRANSPORTATION	391	0	0	0	391
13.00	VOLUNTEER SERVICE COORDINATION	1,497	0	0	350	1,847
14.00	PHARMACY	14,674	0	0	0	14,674
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0
16.00	OTHER GENERAL SERVICE	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0
51.00	HOSPICE ROUTINE HOME CARE	89,365			10,065	99,430
52.00	HOSPICE INPATIENT RESPIRE CARE	520	0	0	98	618
53.00	HOSPICE GENERAL INPATIENT CARE	399	0	0	75	474
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0				0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	172,989	1,683	0	12,925	172,989

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2017

Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>						
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	42,139					4.00
5.00 PLANT OPERATION & MAINTENANCE	4,321	17,737				5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00 HOUSEKEEPING	0	0		0		7.00
8.00 DIETARY	0	0		0	0	8.00
9.00 NURSING ADMINISTRATION	0	0		0		9.00
10.00 ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00 MEDICAL RECORDS	0	0		0		11.00
12.00 STAFF TRANSPORTATION	126	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	595	0		0		13.00
14.00 PHARMACY	4,726	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
<b>LEVEL OF CARE</b>						
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	32,019					51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	199	10,110	0	0	0	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	153	7,627	0	0	0	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
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 THIRFT 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	42,139	17,737	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2017

Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Descriptions	Hospice I					
	NURSING ADMINISTRATIVE	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION	0				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0			10.00
11.00	MEDICAL RECORDS	0		0		11.00
12.00	STAFF TRANSPORTATION	0			517	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	2,442 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
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	508	2,401 51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	5	23 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	4	18 53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM	0			0	0 60.00
61.00	VOLUNTEER PROGRAM	0			0	0 61.00
62.00	FUNDRAISING	0			0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0 63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0 64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0 65.00
66.00	RESIDENTIAL CARE	0			0	0 66.00
67.00	ADVERTISING	0			0	0 67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0 68.00
69.00	THRIFT STORE	0			0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0 71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0 99.00
100.00	TOTAL	0	0	0	517	2,442 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2017

Part I  
Date/Time Prepared:  
5/23/2018 1:12 pm

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	19,400					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				0		17.00
<b>LEVEL OF CARE</b>						
50.00	0	0	0		0	50.00
51.00	19,072	0	0		153,430	51.00
52.00	186	0	0	0	11,141	52.00
53.00	142	0	0	0	8,418	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	19,400	0	0	0	172,989	100.00

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

Provider CCN: 15-0069

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

Worksheet 0-6  
Part II  
Date/Time Prepared:  
5/23/2018 1:12 pm

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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	744					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	55,293			3.00
4.00	ADMINISTRATIVE & GENERAL	744	0	9,996	-42,139	130,850	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	13,416	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	391	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	1,497	0	1,847	13.00
14.00	PHARMACY	0	0	0	0	14,674	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	0	17.00
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			43,058	0	99,430	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	420	0	618	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	322	0	474	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	1,683	0	12,925		42,139	100.00
101.00	UNIT COST MULTIPLIER	2.262097	0.000000	0.233755		0.322041	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPI CE GENERAL SERVICE COSTS  
STATISTICAL BASIS

Provider CCN: 15-0069

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

Worksheet 0-6  
Part 11  
Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Descriptions		Hospice I					
		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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	100					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	57	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	43	0	0	0	0	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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		0		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. 0-6, Part 1)	17,737	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	177.370000	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2017

Part II  
Date/Time Prepared:  
5/23/2018 1:12 pm

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	
<b>GENERAL SERVICE COST CENTERS</b>							
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			10,402			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	14,674		13.00
14.00	PHARMACY			0	0	19,832	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
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	10,226	14,426	19,497	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	100	141	190	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	76	107	145	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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			0	0	0	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. 0-6, Part I)	0	0	517	2,442	19,400	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.049702	0.166417	0.978217	101.00



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

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet 0-6

Hospice CCN: 15-1535

To 12/31/2017

Part II  
Date/Time Prepared:  
5/23/2018 1:12 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>						
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
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
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		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0			99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		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: 15-0069

Period: From 01/01/2017

Worksheet 0-7

Hospice CCN: 15-1535

To 12/31/2017

Date/Time Prepared: 5/23/2018 1:12 pm

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
ANCILLARY SERVICE COST CENTERS								
1.00	PHYSICAL THERAPY	66.00	0.312700	0	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	67.00	0.000000	0	0	0	2.00	
3.00	SPEECH PATHOLOGY	68.00	0.000000	0	0	0	3.00	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.187969	0	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00	
6.00	LABORATORY	60.00	0.152345	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.367370	0	0	0	7.00	
7.01	IV SOLUTIONS	71.01	0.058362	0	0	0	7.01	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00	
9.00	ONCOLOGY	55.00	0.418464	0	0	0	9.00	
10.00	CARDIOLOGY	76.00	0.110439	0	0	0	10.00	
10.97	CARDIAC REHABILITATION	76.97	0.261366	0	0	0	10.97	
11.00	Totals (sum of lines 1-11)						11.00	
Cost Center Descriptions		Charges by LOC (From Provider Records)	Shared Service Costs by LOC					
			HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)		HGIP (col. 1 x col. 5)
			5.00	6.00	7.00	8.00		9.00
ANCILLARY SERVICE COST CENTERS								
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00	
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00	
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00	
6.00	LABORATORY	0	0	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00	
7.01	IV SOLUTIONS	0	0	0	0	0	7.01	
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00	
9.00	ONCOLOGY	0	0	0	0	0	9.00	
10.00	CARDIOLOGY	0	0	0	0	0	10.00	
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97	
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00	

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0069

Period: From 01/01/2017

Worksheet 0-8

Hospice CCN: 15-1535

To 12/31/2017

Date/Time Prepared: 5/23/2018 1:12 pm

		Hospice I		TOTAL	
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID		
		1.00	2.00	3.00	
<b>HOSPICE CONTINUOUS HOME CARE</b>					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, 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)				4.00
5.00	Program cost (line 3 times line 4)	0	0	0	5.00
<b>HOSPICE ROUTINE HOME CARE</b>					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			153,430	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			1,741	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			88.13	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	1,500	111		9.00
10.00	Program cost (line 8 times line 9)	132,195	9,782		10.00
<b>HOSPICE INPATIENT RESPITE CARE</b>					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			11,141	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			17	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			655.35	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)	11,141	0		15.00
<b>HOSPICE GENERAL INPATIENT CARE</b>					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			8,418	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			13	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			647.54	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	13	0		19.00
20.00	Program cost (line 18 times line 19)	8,418	0		20.00
<b>TOTAL HOSPICE CARE</b>					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			172,989	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			1,771	22.00
23.00	Average cost per diem (line 21 divided by line 22)			97.68	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/23/2018 1:12 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,015,100	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		39,368	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)		32.37	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)		1,054,468	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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