

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/26/2017 4:35 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: 5/26/2017 Time: 4:35 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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOOD SAMARITAN HOSPITAL ( 15-0042 ) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	1,592	-3,995	0	0	1.00
2.00 Subprovider - IPF	0	8,134	108		0	2.00
3.00 Subprovider - IRF	0	15,934	-8		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	25,660	-3,895	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-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 4:34 pm					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN Zip Code: 47591		4.00 County: KNOX					
1.00 Street: 520 SOUTH 7TH STREET		2.00 City: VINCENNES									
		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		
		V			XVIII			XIX			
Hospital and Hospital -Based Component Identification:											
3.00	Hospital	GOOD SAMARI TAN HOSPI TAL	150042	99915	1	07/01/1966	N	P	O	3.00	
4.00	Subprovider - IPF	GOOD SAMARI TAN HOSPI TAL	15S042	99915	4	01/01/1984	N	P	O	4.00	
5.00	Subprovider - IRF	GOOD SAMARI TAN - REHAB	15T042	99915	5	01/01/2001	N	P	O	5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital -Based SNF									9.00	
10.00	Hospital -Based NF									10.00	
11.00	Hospital -Based OLTC									11.00	
12.00	Hospital -Based HHA	GOOD SAMARI TAN HOME CARE	157432	99915		06/27/1995	N	P	N	12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital -Based Hospice	GOOD SAMARI TAN LINCOLN TRAIL HOSPI CE	151526	99915		01/01/1984				14.00	
15.00	Hospital -Based Health Clinic - RHC									15.00	
16.00	Hospital -Based Health Clinic - FQHC									16.00	
17.00	Hospital -Based (CMHC) I									17.00	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2016	12/31/2016			20.00
21.00	Type of Control (see instructions)						9				21.00
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							2	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	425	181	204	447	2,044	0			24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	72	20	0	34	175				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.		2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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)(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		Y	40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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	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	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.		N		N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N		N	48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)		Y			60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
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 and enter in column 4, direct GME FTE unweighted count.						0.00	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 and enter in column 4, direct GME FTE unweighted count.						0.00	0.00
						1.00		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>								
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 64-67. (see instructions)						N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
			1.00	2.00	3.00			
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)						0.00	0.000000
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						0.00	0.000000

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		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
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
				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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V		
				XIX		
				1.00		
				2.00		
<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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX			
		1.00		2.00			
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	
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a critical access hospital (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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical		Speech		Respiratory	
		1.00		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		109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
						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	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,124,083		4,666		0	
						1.00 2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? 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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 4:34 pm	
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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.	N		N		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		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
168.01	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 4:34 pm
		Beginning 1.00	Ending 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)	01/01/2016	12/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/26/2017 4:34 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	A	05/17/2017			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/25/2017	Y	04/25/2017		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/26/2017 4:34 pm	
		Description	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	0	1.00	3.00	20.00
			N	N	
		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			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<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.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<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.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<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.			Y	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?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
<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.	BOB		BRANDENBURG	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173833787		B BRANDENBURG@BKD.COM	43.00

		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.	PARTNER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/26/2017 4:34 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	162	59,292	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)		162	59,292	0.00		0 7.00
8.00 INTENSIVE CARE UNIT	31.00	30	10,980	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						0 13.00
14.00 Total (see instructions)		192	70,272	0.00		0 14.00
15.00 CAH visits						0 15.00
16.00 SUBPROVIDER - IPF	40.00	22	8,052			0 16.00
17.00 SUBPROVIDER - IRF	41.00	25	9,150			0 17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					0 22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					0 26.25
27.00 Total (sum of lines 14-26)		239				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/26/2017 4:34 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	10,654	268	14,197			1.00
2.00 HMO and other (see instructions)	852	2,817				2.00
3.00 HMO IPF Subprovider	36	0				3.00
4.00 HMO IRF Subprovider	104	229				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)	10,654	268	14,197			7.00
8.00 INTENSIVE CARE UNIT	2,399	135	7,104			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		22	1,142			13.00
14.00 Total (see instructions)	13,053	425	22,443	0.00	1,537.06	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,026	0	2,960	0.00	29.51	16.00
17.00 SUBPROVIDER - IRF	6,072	72	7,794	0.00	63.85	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	9.46	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				0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	1,639.88	27.00
28.00 Observation Bed Days		0	4,382			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	59	119			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/26/2017 4:34 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	3,056	528	5,459	1.00
2.00 HMO and other (see instructions)				191	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		3,056	528	5,459	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		165	164	607	16.00
17.00 SUBPROVIDER - IRF	0.00	0		517	9	677	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							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part II Date/Time Prepared: 5/26/2017 4:34 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 Rel ated to Sal ari es 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	104,734,956	0	104,734,956	3,462,497.70	30.25
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		267,130	0	267,130	1,304.37	204.80
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		5,070,305	0	5,070,305	29,600.43	171.29
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)		33,410,245	2,725,247	36,135,492	836,683.00	43.19
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		594,174	0	594,174	4,274.50	139.00
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		334,172	0	334,172	3,790.00	88.17
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)		23,932,732	0	23,932,732		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		7,922,936	0	7,922,936		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		12,857	0	12,857		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		273,205	0	273,205		
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		0	0	0		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/26/2017 4:34 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	4,588,827	0	4,588,827	269,636.54	17.02	26.00
27.00	Administrative & General	5.00	8,557,051	869,759	9,426,810	290,933.02	32.40	27.00
28.00	Administrative & General under contract (see inst.)		459,001	0	459,001	2,234.12	205.45	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,135,702	173,952	2,309,654	108,407.93	21.31	30.00
31.00	Laundry & Linen Service	8.00	176,053	0	176,053	15,257.57	11.54	31.00
32.00	Housekeeping	9.00	1,978,435	0	1,978,435	148,036.70	13.36	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,303,335	-962,268	341,067	23,154.53	14.73	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	962,268	962,268	65,406.00	14.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,403,243	57,984	1,461,227	39,188.54	37.29	38.00
39.00	Central Services and Supply	14.00	343,198	0	343,198	25,255.53	13.59	39.00
40.00	Pharmacy	15.00	3,191,249	-576,364	2,614,885	65,446.30	39.95	40.00
41.00	Medical Records & Medical Records Library	16.00	2,466,302	0	2,466,302	124,969.31	19.74	41.00
42.00	Social Service	17.00	5,798,396	-3,826,942	1,971,454	98,052.11	20.11	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/26/2017 4:34 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)	100,123,652	0	100,123,652	3,435,131.39	29.15	1.00
2.00	Excluded area salaries (see instructions)	33,410,245	2,725,247	36,135,492	836,683.00	43.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)	66,713,407	-2,725,247	63,988,160	2,598,448.39	24.63	3.00
4.00	Subtotal other wages & related costs (see inst.)	928,346	0	928,346	8,064.50	115.12	4.00
5.00	Subtotal wage-related costs (see inst.)	23,945,589	0	23,945,589	0.00	37.42	5.00
6.00	Total (sum of lines 3 thru 5)	91,587,342	-2,725,247	88,862,095	2,606,512.89	34.09	6.00
7.00	Total overhead cost (see instructions)	32,400,792	-3,301,611	29,099,181	1,275,978.20	22.81	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/26/2017 4:34 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)	6,436,200	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)	17,243,132	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	0	9.00
10.00	Dental, Hearing and Vision Plan	590,334	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	195,505	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)	344,812	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	5,168,883	17.00
18.00	Medicare Taxes - Employers Portion Only	1,527,656	18.00
19.00	Unemployment Insurance	0	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	635,208	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	32,141,730	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: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/26/2017 4:34 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	594,174	32,141,730	1.00
2.00	Hospital	594,174	32,141,730	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2016 To 12/31/2016	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/26/2017 4:34 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	
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
1.00	Hospice Continuous Home Care						1.00	
2.00	Hospice Routine Home Care						2.00	
3.00	Hospice Inpatient Respite Care						3.00	
4.00	Hospice General Inpatient Care						4.00	
5.00	Total Hospice Days						5.00	
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care						6.00	
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00	
8.00	Average Length of Stay (line 5 / line 6)						8.00	
9.00	Unduplicated census count						9.00	

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)
		1.00	2.00	3.00	4.00
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0
11.00	Hospice Routine Home Care	3,841	0	3,412	7,253
12.00	Hospice Inpatient Respite Care	0	0	21	21
13.00	Hospice General Inpatient Care	344	0	190	534
14.00	Total Hospice Days	4,185	0	3,623	7,808
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0
16.00	Hospice General Inpatient Care	0	0	0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/26/2017 4:34 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)		0.268869	1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid		8,313,145	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 or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		700,482	5.00
6.00	Medicaid charges		41,953,704	6.00
7.00	Medicaid cost (line 1 times line 6)		11,280,050	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)		2,266,423	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>Uncompensated care (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)		2,266,423	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Charity care charges for the entire facility (see instructions)	3,983,922	6,198,240	10,182,162
21.00	Cost of patients approved for charity care (line 1 times line 20)	1,071,153	1,666,515	2,737,668
22.00	Partial payment by patients approved for charity care	58,364	24,892	83,256
23.00	Cost of charity care (line 21 minus line 22)	1,012,789	1,641,623	2,654,412
				1.00
24.00	Does the amount in 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," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		19,967,903	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		494,653	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		19,473,250	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		5,235,753	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,890,165	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		10,156,588	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet A	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	CAP REL COSTS-BLDG & FIXT	0	0	21,340,380	21,340,380	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,527,179	-8,075,345	1,451,834	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	653,713	2,387,534	29,803,864	32,845,111	4.00
4.01	00401	COMMUNICATIONS	250,728	103,010	-101,809	251,929	4.01
4.02	00402	PURCHASING & RECEIVING	648,596	554,755	-305,821	897,530	4.02
4.03	00403	REGISTRATION	961,144	494,621	-441,578	1,014,187	4.03
4.04	00404	PATIENT ACCOUNTS	2,074,646	2,953,055	-875,833	4,151,868	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	8,557,051	23,241,894	-6,320,564	25,478,381	5.00
7.00	00700	OPERATION OF PLANT	2,135,702	4,680,700	-779,217	6,037,185	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	176,053	315,061	-209,902	281,212	8.00
9.00	00900	HOUSEKEEPING	1,978,435	1,190,355	-963,184	2,205,606	9.00
10.00	01000	DIETARY	1,303,335	1,929,647	-2,579,014	653,968	10.00
11.00	01100	CAFETERIA	0	0	2,002,650	2,002,650	11.00
13.00	01300	NURSING ADMINISTRATION	1,403,243	944,920	-620,410	1,727,753	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	343,198	403,637	-220,596	526,239	14.00
15.00	01500	PHARMACY	3,191,249	13,115,327	-13,251,171	3,055,405	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,466,302	1,516,434	-959,041	3,023,695	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	5,798,396	3,297,485	-6,704,347	2,391,534	17.01
23.00	02300	PARAMEDICAL PROGRAM-RADIOLOGY	198,386	89,049	287,435	217,353	23.00
23.01	02302	PARAMEDICAL PROGRAM-LAB	14,515	7,142	21,657	16,724	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,294,795	4,689,776	-3,464,895	6,519,676	30.00
31.00	03100	INTENSIVE CARE UNIT	3,451,316	1,748,692	-1,460,452	3,739,556	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	773,732	773,732	40.00
41.00	04100	SUBPROVIDER - IRF	2,998,895	1,199,436	-909,204	3,289,127	41.00
43.00	04300	NURSERY	306,123	154,548	-120,850	339,821	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,478,275	6,401,343	-4,495,888	5,383,730	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	987,801	1,161,126	-912,936	1,235,991	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,015,128	360,237	-340,850	1,034,515	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,773,930	6,828,738	-4,285,631	6,317,037	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	830,426	694,336	-458,785	1,065,977	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	195,947	65,976	-54,209	207,714	54.08
60.00	06000	LABORATORY	2,406,404	5,038,529	-3,347,948	4,096,985	60.00
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0	0	719,274	719,274	63.00
65.00	06500	RESPIRATORY THERAPY	1,946,419	944,198	-821,778	2,068,839	65.00
66.00	06600	PHYSICAL THERAPY	2,698,322	1,058,543	-897,142	2,859,723	66.00
69.00	06900	ELECTROCARDIOLOGY	4,752,902	3,179,294	-2,726,231	5,205,965	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	315,419	204,980	-153,702	366,697	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	9,177,994	9,177,994	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,003,500	3,003,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	187,772	2,134,117	12,030,479	14,352,368	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,159,926	2,466,130	-1,803,587	1,822,469	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	652,384	-97,592	554,792	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	2,427,981	1,532,739	-1,025,870	2,934,850	90.00
91.00	09100	EMERGENCY	4,086,692	7,412,426	-1,628,346	9,870,772	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	67,342	127,145	194,487	120,060	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE		2,014,878	-2,014,878	0	113.00
116.00	11600	HOSPICE	483,224	595,173	-192,306	886,091	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,019,731	117,416,549	5,081,519	197,517,799	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,543,499	12,578,416	-7,207,756	33,914,159	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	180,017	144,914	-77,066	247,865	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	143,780	865,997	-60,753	949,024	194.02
194.03	07953	MH RESIDENTIAL	385,473	193,460	-146,330	432,603	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	194.04
194.05	07955	MOB	177,746	105,036	-54,624	228,158	194.05
194.06	07956	FOUNDATION	124,422	328,116	-31,103	421,435	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	18,835	2,738	-195	21,378	194.08
194.09	07959	NRCC	141,453	137,687	2,496,308	2,775,448	194.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016	Worksheet A Date/Time Prepared: 5/26/2017 4:34 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	
200.00	TOTAL (SUM OF LINES 118-199)	104,734,956	131,772,913	236,507,869	0	236,507,869	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A  
Date/Time Prepared:  
5/26/2017 4:34 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	CAP REL COSTS-BLDG & FIXT	0	21,340,380	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-331,227	1,120,607	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-373,197	32,471,914	4.00
4.01	00401	COMMUNICATIONS	0	251,929	4.01
4.02	00402	PURCHASING & RECEIVING	-275,285	622,245	4.02
4.03	00403	REGISTRATION	0	1,014,187	4.03
4.04	00404	PATIENT ACCOUNTS	-219,418	3,932,450	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-6,235,747	19,242,634	5.00
7.00	00700	OPERATION OF PLANT	-3,003	6,034,182	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-5,801	275,411	8.00
9.00	00900	HOUSEKEEPING	0	2,205,606	9.00
10.00	01000	DIETARY	-533,324	120,644	10.00
11.00	01100	CAFETERIA	-521,827	1,480,823	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,727,753	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,014	524,225	14.00
15.00	01500	PHARMACY	-769	3,054,636	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,018	3,016,677	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	-784,826	1,606,708	17.01
23.00	02300	PARAMED PGMR-RADIOLOGY	-57,306	160,047	23.00
23.01	02302	PARAMED PGMR-LAB	0	16,724	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-219	6,519,457	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,739,556	31.00
40.00	04000	SUBPROVIDER - I PF	0	773,732	40.00
41.00	04100	SUBPROVIDER - I RF	-6,020	3,283,107	41.00
43.00	04300	NURSERY	0	339,821	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-1,287,851	4,095,879	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	0	1,235,991	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,034,515	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-347,448	5,969,589	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	1,065,977	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	-48,510	159,204	54.08
60.00	06000	LABORATORY	-60,272	4,036,713	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	719,274	63.00
65.00	06500	RESPIRATORY THERAPY	-1,737	2,067,102	65.00
66.00	06600	PHYSICAL THERAPY	-3,454	2,856,269	66.00
69.00	06900	ELECTROCARDIOLOGY	-2,086,696	3,119,269	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	-9,865	356,832	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,177,994	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,003,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-418,858	13,933,510	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-69	1,822,400	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	-217,189	337,603	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-1,163,696	1,771,154	90.00
91.00	09100	EMERGENCY	-5,397,950	4,472,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	120,060	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	886,091	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-20,400,596	177,117,203	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,914,159	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	247,865	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	949,024	194.02
194.03	07953	MH RESIDENTIAL	0	432,603	194.03
194.04	07954	UNUSED SPACE	0	0	194.04
194.05	07955	MOB	0	228,158	194.05
194.06	07956	FOUNDATION	0	421,435	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	21,378	194.08
194.09	07959	NRCC	0	2,775,448	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-20,400,596	216,107,273	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
<b>A - DRUGS CHARGED TO PATIENTS</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,456,365	1.00	
	O		0	11,456,365		
<b>B - MEDICAL SUPPLIES CHARGED TO PATIENTS</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	9,177,994	1.00	
2.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	719,274	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
	O		0	9,897,268		
<b>C - EMPLOYEE BENEFITS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	29,879,114	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00
43.00		0.00	0	0	43.00
44.00		0.00	0	0	44.00
45.00		0.00	0	0	45.00
46.00		0.00	0	0	46.00
0			0	29,879,114	
<b>D - INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,009,353	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	5,525	2.00
0			0	2,014,878	
<b>E - DEPRECIATION EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,858,391	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00
43.00		0.00	0	0	43.00
0			0	10,858,391	
<b>G - INSURANCE EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	397,291	1.00
0			0	397,291	
<b>H - MENTAL HEALTH OVERHEAD</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	869,759	185,329	1.00
2.00	OPERATION OF PLANT	7.00	173,952	37,066	2.00
3.00	NURSING ADMINISTRATION	13.00	57,984	12,355	3.00
4.00	SUBPROVIDER - IPF	40.00	637,824	135,908	4.00
5.00	NRCC	194.09	2,087,423	444,790	5.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
	0		3,826,942	815,448		
<b>I - IMPL. DEV. CHARGED TO PATIENT</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,003,500	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	
	0		0	3,003,500		
<b>J - ONCOLOGY</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00	576,364	70,493	1.00	
	0		576,364	70,493		
<b>K - DIETARY</b>						
1.00	CAFETERIA	11.00	962,268	1,040,382	1.00	
	0		962,268	1,040,382		
<b>L - DEPRECIATION EXPENSE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,611,091	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,893,529	2.00	
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	594,711	3.00	
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	815,491	4.00	
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,490,230	5.00	
6.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,989	6.00	
7.00	CAP REL COSTS-BLDG & FIXT	1.00	0	668,304	7.00	
	0		0	8,075,345		
500.00	Grand Total: Increases		5,365,574	77,508,475	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-6  
Date/Time Prepared:  
5/26/2017 4:34 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - DRUGS CHARGED TO PATIENTS</b>							
1.00	PHARMACY	15.00	0	11,456,365	0		1.00
	O		0	11,456,365			
<b>B - MEDICAL SUPPLIES CHARGED TO PATIENTS</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	59,827	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	15,847	0		2.00
3.00	OPERATION OF PLANT	7.00	0	60	0		3.00
4.00	HOUSEKEEPING	9.00	0	153	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	4	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,384	0		6.00
7.00	PHARMACY	15.00	0	66,721	0		7.00
8.00	MENTAL HEALTH OVERHEAD	17.01	0	1,439	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	1,109,347	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	99,901	0		10.00
11.00	SUBPROVIDER - IRF	41.00	0	18,704	0		11.00
12.00	NURSERY	43.00	0	9,017	0		12.00
13.00	OPERATING ROOM	50.00	0	951,348	0		13.00
14.00	ENDOSCOPY	51.01	0	338,914	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	17,849	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,176,848	0		16.00
17.00	RADIOLOGY-NON-CAMPUS	54.01	0	65,783	0		17.00
18.00	RADIOLOGY-GSH BREAST CENTER	54.08	0	2,938	0		18.00
19.00	LABORATORY	60.00	0	2,325,402	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	176,817	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	46,414	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	1,015,875	0		22.00
23.00	NEURODIAGNOSTICS	70.01	0	183	0		23.00
24.00	INPATIENT DIALYSIS	76.01	0	4,221	0		24.00
25.00	ASC (NON-DISTINCT PART)	75.00	0	577,794	0		25.00
26.00	CLINIC	90.00	0	533,401	0		26.00
27.00	EMERGENCY	91.00	0	151,341	0		27.00
28.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	47,750	0		28.00
29.00	HOSPICE	116.00	0	5,236	0		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,058,204	0		30.00
31.00	COMMUNITY HEALTH SERVICES	194.00	0	15,566	0		31.00
32.00	MH RESIDENTIAL	194.03	0	298	0		32.00
33.00	MOB	194.05	0	802	0		33.00
34.00	FOUNDATION	194.06	0	238	0		34.00
35.00	NRCC	194.09	0	642	0		35.00
	O		0	9,897,268			
<b>C - EMPLOYEE BENEFITS</b>							
1.00	COMMUNICATIONS	4.01	0	100,598	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	286,341	0		2.00
3.00	REGISTRATION	4.03	0	430,886	0		3.00
4.00	PATIENT ACCOUNTS	4.04	0	827,544	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	2,366,588	0		5.00
6.00	OPERATION OF PLANT	7.00	0	731,738	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	104,315	0		7.00
8.00	HOUSEKEEPING	9.00	0	925,546	0		8.00
9.00	DIETARY	10.00	0	520,953	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	432,352	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	165,302	0		11.00
12.00	PHARMACY	15.00	0	916,000	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	939,998	0		13.00
14.00	MENTAL HEALTH OVERHEAD	17.01	0	1,972,044	0		14.00
15.00	PARAMED PGRM-RADIOLOGY	23.00	0	67,658	0		15.00
16.00	PARAMED PGRM-LAB	23.01	0	1,370	0		16.00
17.00	ADULTS & PEDIATRICS	30.00	0	1,661,276	0		17.00
18.00	INTENSIVE CARE UNIT	31.00	0	1,101,577	0		18.00
19.00	SUBPROVIDER - IRF	41.00	0	828,164	0		19.00
20.00	NURSERY	43.00	0	88,034	0		20.00
21.00	OPERATING ROOM	50.00	0	584,950	0		21.00
22.00	ENDOSCOPY	51.01	0	332,993	0		22.00
23.00	DELIVERY ROOM & LABOR ROOM	52.00	0	278,829	0		23.00
24.00	OPERATING ROOM	50.00	0	349,365	0		24.00
25.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,137,468	0		25.00
26.00	RADIOLOGY-NON-CAMPUS	54.01	0	256,535	0		26.00
27.00	RADIOLOGY-GSH BREAST CENTER	54.08	0	51,271	0		27.00
28.00	LABORATORY	60.00	0	901,422	0		28.00
29.00	RESPIRATORY THERAPY	65.00	0	577,803	0		29.00
30.00	PHYSICAL THERAPY	66.00	0	825,016	0		30.00
31.00	ELECTROCARDIOLOGY	69.00	0	1,028,936	0		31.00
32.00	NEURODIAGNOSTICS	70.01	0	103,170	0		32.00
33.00	DRUGS CHARGED TO PATIENTS	73.00	0	72,578	0		33.00

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RECLASSIFICATIONS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-6  
Date/Time Prepared:  
5/26/2017 4:34 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
34.00	ASC (NON-DISTINCT PART)	75.00	0	365,115	0	34.00
35.00	CLINIC	90.00	0	490,089	0	35.00
36.00	EMERGENCY	91.00	0	1,338,315	0	36.00
37.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	25,929	0	37.00
38.00	HOSPICE	116.00	0	175,963	0	38.00
39.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,137,686	0	39.00
40.00	COMMUNITY HEALTH SERVICES	194.00	0	60,859	0	40.00
41.00	MARKETING AND PUBLIC RELATIONS	194.02	0	52,701	0	41.00
42.00	MH RESIDENTIAL	194.03	0	143,953	0	42.00
43.00	MOB	194.05	0	53,822	0	43.00
44.00	FOUNDATION	194.06	0	30,865	0	44.00
45.00	INDUSTRIAL HEALTH	194.08	0	195	0	45.00
46.00	NRCC	194.09	0	35,002	0	46.00
	O		0	29,879,114		
<b>D - INTEREST EXPENSE</b>						
1.00	INTEREST EXPENSE	113.00	0	2,014,878	11	1.00
2.00	O	0.00	0	0	0	2.00
	O		0	2,014,878		
<b>E - DEPRECIATION EXPENSE</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,423	9	1.00
2.00	COMMUNICATIONS	4.01	0	1,211	9	2.00
3.00	PURCHASING & RECEIVING	4.02	0	19,480	9	3.00
4.00	REGISTRATION	4.03	0	10,692	9	4.00
5.00	PATIENT ACCOUNTS	4.04	0	48,289	9	5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	0	4,601,451	9	6.00
7.00	OPERATION OF PLANT	7.00	0	258,437	9	7.00
8.00	LAUNDRY & LINEN SERVICE	8.00	0	105,587	9	8.00
9.00	HOUSEKEEPING	9.00	0	37,485	9	9.00
10.00	DIETARY	10.00	0	55,411	9	10.00
11.00	NURSING ADMINISTRATION	13.00	0	258,393	9	11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	52,799	9	12.00
13.00	PHARMACY	15.00	0	165,228	9	13.00
14.00	MEDICAL RECORDS & LIBRARY	16.00	0	19,043	9	14.00
15.00	MENTAL HEALTH OVERHEAD	17.01	0	88,474	9	15.00
16.00	PARAMED PGRM-RADIOLOGY	23.00	0	2,424	9	16.00
17.00	PARAMED PGRM-LAB	23.01	0	3,563	9	17.00
18.00	ADULTS & PEDIATRICS	30.00	0	315,976	9	18.00
19.00	INTENSIVE CARE UNIT	31.00	0	251,763	9	19.00
20.00	SUBPROVIDER - IRF	41.00	0	62,336	9	20.00
21.00	NURSERY	43.00	0	23,799	9	21.00
22.00	OPERATING ROOM	50.00	0	618,730	9	22.00
23.00	ENDOSCOPY	51.01	0	238,263	9	23.00
24.00	DELIVERY ROOM & LABOR ROOM	52.00	0	44,160	9	24.00
25.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,953,671	9	25.00
26.00	RADIOLOGY-NON-CAMPUS	54.01	0	136,467	9	26.00
27.00	LABORATORY	60.00	0	121,124	9	27.00
28.00	RESPIRATORY THERAPY	65.00	0	67,158	9	28.00
29.00	PHYSICAL THERAPY	66.00	0	25,712	9	29.00
30.00	ELECTROCARDIOLOGY	69.00	0	674,116	9	30.00
31.00	NEURODIAGNOSTICS	70.01	0	48,999	9	31.00
32.00	DRUGS CHARGED TO PATIENTS	73.00	0	165	9	32.00
33.00	INPATIENT DIALYSIS	76.01	0	93,371	9	33.00
34.00	ASC (NON-DISTINCT PART)	75.00	0	294,280	9	34.00
35.00	CLINIC	90.00	0	2,380	9	35.00
36.00	EMERGENCY	91.00	0	107,884	9	36.00
37.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	748	9	37.00
38.00	HOSPICE	116.00	0	11,107	9	38.00
39.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,759	9	39.00
40.00	COMMUNITY HEALTH SERVICES	194.00	0	641	9	40.00
41.00	MARKETING AND PUBLIC RELATIONS	194.02	0	8,052	9	41.00
42.00	MH RESIDENTIAL	194.03	0	2,079	9	42.00
43.00	NRCC	194.09	0	261	0	43.00
	O		0	10,858,391		
<b>G - INSURANCE EXPENSE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	397,291	12	1.00
	O		0	397,291		
<b>H - MENTAL HEALTH OVERHEAD</b>						
1.00	MENTAL HEALTH OVERHEAD	17.01	3,826,942	815,448	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
0		3,826,942	815,448			
<b>I - IMPL. DEV. CHARGED TO PATIENT</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	111	0	1.00
2.00	EMERGENCY	91.00	0	30,806	0	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	107	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	378,296	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	7,211	0	5.00
6.00	OPERATING ROOM	50.00	0	1,991,495	0	6.00
7.00	ENDOSCOPY	51.01	0	2,766	0	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	12	0	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	7,304	0	9.00
10.00	NEURODIAGNOSTICS	70.01	0	1,350	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17,644	0	11.00
12.00	ASC (NON-DISTINCT PART)	75.00	0	566,398	0	12.00
0			0	3,003,500		
<b>J - ONCOLOGY</b>						
1.00	PHARMACY	15.00	576,364	70,493	0	1.00
0			576,364	70,493		
<b>K - DIETARY</b>						
1.00	DIETARY	10.00	962,268	1,040,382	0	1.00
0			962,268	1,040,382		
<b>L - DEPRECIATION EXPENSE</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,075,345	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	9	3.00
4.00		0.00	0	0	9	4.00
5.00		0.00	0	0	9	5.00
6.00		0.00	0	0	9	6.00
7.00		0.00	0	0	9	7.00
0			0	8,075,345		
500.00	Grand Total: Decreases		5,365,574	77,508,475		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/26/2017 4:34 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	7,202,985	100,000	0	100,000	390,337 1.00	
2.00	Land Improvements	9,191,361	84,389	0	84,389	0 2.00	
3.00	Buildings and Fixtures	0	0	0	0	0 3.00	
4.00	Building Improvements	122,958,810	3,643,159	0	3,643,159	0 4.00	
5.00	Fixed Equipment	0	0	0	0	0 5.00	
6.00	Movable Equipment	246,310,658	46,031,256	0	46,031,256	38,018,275 6.00	
7.00	HIT designated Assets	0	0	0	0	0 7.00	
8.00	Subtotal (sum of lines 1-7)	385,663,814	49,858,804	0	49,858,804	38,408,612 8.00	
9.00	Reconciling Items	0	0	0	0	0 9.00	
10.00	Total (line 8 minus line 9)	385,663,814	49,858,804	0	49,858,804	38,408,612 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	6,912,648	0			1.00	
2.00	Land Improvements	9,275,750	0			2.00	
3.00	Buildings and Fixtures	0	0			3.00	
4.00	Building Improvements	126,601,969	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	254,323,639	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	397,114,006	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	397,114,006	0			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,527,179	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,527,179	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,527,179				2.00
3.00	Total (sum of lines 1-2)	0	9,527,179				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	142,790,367	0	142,790,367	0.359570	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	254,323,639	0	254,323,639	0.640430	0	2.00
3.00	Total (sum of lines 1-2)	397,114,006	0	397,114,006	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	18,933,736	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,120,607	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,054,343	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,009,353	397,291	0	0	21,340,380	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,120,607	2.00
3.00	Total (sum of lines 1-2)	2,009,353	397,291	0	0	22,460,987	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-8

Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-247,249		PURCHASING & RECEIVING	4.02	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)	B	-30,856		ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-11,116,215				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	-521,827		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			0		0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-418,858		DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-8

Date/Time Prepared:  
5/26/2017 4:34 pm

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		
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 OTHER MISC FEES	B	-28,036	PURCHASING & RECEIVING	4.02		0	33.00
33.01 OTHER MISC FEES	B	-21,389	PATIENT ACCOUNTS	4.04		0	33.01
33.02 OTHER MISC FEES	B	-3,003	OPERATION OF PLANT	7.00		0	33.02
33.03 OTHER MISC FEES	B	-5,801	LAUNDRY & LINEN SERVICE	8.00		0	33.03
33.04 OTHER MISC FEES	B	-533,324	DIETARY	10.00		0	33.04
33.05 OTHER MISC FEES	B	-769	PHARMACY	15.00		0	33.05
33.06 OTHER MISC FEES	B	-7,018	MEDICAL RECORDS & LIBRARY	16.00		0	33.06
33.07 OTHER MISC FEES	B	-36,929	MENTAL HEALTH OVERHEAD	17.01		0	33.07
33.08 OTHER MISC FEES	B	-725	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.08
33.09 OTHER MISC FEES	B	-2,014	CENTRAL SERVICES & SUPPLY	14.00		0	33.09
33.10 PHYSICIAN ON-CALL TIME	A	-175	SUBPROVIDER - IRF	41.00		0	33.10
33.11 OTHER MISC FEES	B	-219	ADULTS & PEDIATRICS	30.00		0	33.11
33.12 PROVIDER ASSESSMENT FEE	A	-6,018,200	ADMINISTRATIVE & GENERAL	5.00		0	33.12
33.13 OTHER MISC FEES	B	-3,366	PHYSICAL THERAPY	66.00		0	33.13
33.14 FOOD SERVICE	B	-270	ELECTROCARDIOLOGY	69.00		0	33.14
33.15 OTHER MISC FEES	B	-4,468	CLINIC	90.00		0	33.15
33.16 ANESTHESIOLOGY BENEFITS	A	-343,319	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.16
33.17 RADIOLOGY - STUDENT TUITION	B	-57,306	PARAMED PGMR-RADIOLOGY	23.00		0	33.17
33.18 RENTAL INCOME	B	-18,276	MENTAL HEALTH OVERHEAD	17.01		0	33.18
33.19 RENTAL INCOME	B	-16,023	OPERATING ROOM	50.00		0	33.19
33.20 RENTAL INCOME	B	-1,480	RADIOLOGY-DIAGNOSTIC	54.00		0	33.20
33.21 RENTAL INCOME	B	-100	ELECTROCARDIOLOGY	69.00		0	33.21
33.23 RENTAL INCOME	B	-211,354	INPATIENT DIALYSIS	76.01		0	33.23
33.24 RENTAL INCOME	B	-3,800	CLINIC	90.00		0	33.24
33.25 AHA USEFUL LIVES CARRYFORWARD	A	-95	CAP REL COSTS-MVBLE EQUIP	2.00		9	33.25
33.26 HEALTH PAVILION AHA CARRYFORWARD	A	-26,044	CAP REL COSTS-MVBLE EQUIP	2.00		9	33.26
33.27 ADVANCE EMT TRAINING	A	-1,737	RESPIRATORY THERAPY	65.00		0	33.27
33.28 1990 ASSETS - AHA LIVES CARRYFORWARD	A	-2,119	CAP REL COSTS-MVBLE EQUIP	2.00		9	33.28
33.30 INTEREST INCOME	B	-302,969	CAP REL COSTS-MVBLE EQUIP	2.00		9	33.30
33.31 PHYSICIAN BILLING COSTS	A	-198,029	PATIENT ACCOUNTS	4.04		0	33.31
33.32 2004 SURETY BOND EXPENSE	A	-20,525	ADMINISTRATIVE & GENERAL	5.00		0	33.32
33.33 DONATIONS EXPENSE	A	-52,543	ADMINISTRATIVE & GENERAL	5.00		0	33.33
33.35 PHYSICIAN EMPLOYEE BENEFIT	A	-29,153	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.35
33.36 PHYSICIAN ON-CALL TIME	A	-146,143	ADMINISTRATIVE & GENERAL	5.00		0	33.36
33.37 ADVERTISING	A	-50	ADMINISTRATIVE & GENERAL	5.00		0	33.37
33.38 ADVERTISING	A	-919	SUBPROVIDER - IRF	41.00		0	33.38
33.43 ADVERTISING	A	-240	RADIOLOGY-DIAGNOSTIC	54.00		0	33.43
33.44 ADVERTISING	A	-88	PHYSICAL THERAPY	66.00		0	33.44
33.46 2012 BOND ISSUE COSTS	A	45,855	ADMINISTRATIVE & GENERAL	5.00		0	33.46
33.47 IHA LOBBYING OFFSET	A	-11,527	ADMINISTRATIVE & GENERAL	5.00		0	33.47
33.48 INDIANA CHAMBER LOBBYING OFFSET	A	-125	ADMINISTRATIVE & GENERAL	5.00		0	33.48
33.49 BEAUTY SHOP EXPENSE	A	-740	ADMINISTRATIVE & GENERAL	5.00		0	33.49
33.50 ALCOHOLIC BEVERAGES	A	-893	ADMINISTRATIVE & GENERAL	5.00		0	33.50
33.51 TRADE, QUANTITY, AND TIME DISCOUNTS	B	-11	MENTAL HEALTH OVERHEAD	17.01		0	33.51
33.53 TRADE, QUANTITY, AND TIME DISCOUNTS	B	-63	SUBPROVIDER - IRF	41.00		0	33.53
33.54 TRADE, QUANTITY, AND TIME DISCOUNTS	B	-69	ASC (NON-DISTINCT PART)	75.00		0	33.54
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-20,400,596					50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-8-2

Date/Time Prepared:  
5/26/2017 4:34 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	17.01	MENTAL HEALTH OVERHEAD	775,164	715,653	59,511	211,500	448	1.00
2.00	41.00	SUBPROVIDER - IRF	90,175	175	90,000	211,500	839	2.00
3.00	50.00	OPERATING ROOM	1,271,828	1,271,828	0	0	0	3.00
4.00	54.00	DR. O	345,728	345,728	0	211,500	0	4.00
5.00	54.08	DR. G	64,938	48,510	16,428	271,900	170	5.00
6.00	60.00	DR. Q	129,020	60,272	68,748	211,500	1,562	6.00
7.00	65.00	DR. R	18,000	0	18,000	211,500	300	7.00
8.00	69.00	ELECTROCARDIOLOGY	2,142,251	1,977,998	164,253	211,500	550	8.00
9.00	70.01	NEURODIAGNOSTICS	18,000	0	18,000	211,500	80	9.00
10.00	76.01	DR. S	40,000	0	40,000	211,500	336	10.00
11.00	75.00	ASC (NON-DIAGNOSTIC PART)	12,000	0	12,000	211,500	144	11.00
12.00	90.00	DR. L	1,169,257	1,142,319	26,938	211,500	136	12.00
13.00	91.00	EMERGENCY	5,451,740	5,364,316	87,424	211,500	529	13.00
200.00			11,528,101	10,926,799	601,302		5,094	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	17.01	MENTAL HEALTH OVERHEAD	45,554	2,278	0	0	0	1.00
2.00	41.00	SUBPROVIDER - IRF	85,312	4,266	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	DR. O	0	0	0	0	0	4.00
5.00	54.08	DR. G	22,223	1,111	0	0	0	5.00
6.00	60.00	DR. Q	158,828	7,941	0	0	0	6.00
7.00	65.00	DR. R	30,505	1,525	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	55,925	2,796	0	0	0	8.00
9.00	70.01	NEURODIAGNOSTICS	8,135	407	0	0	0	9.00
10.00	76.01	DR. S	34,165	1,708	0	0	0	10.00
11.00	75.00	ASC (NON-DIAGNOSTIC PART)	14,642	732	0	0	0	11.00
12.00	90.00	DR. L	13,829	691	0	0	0	12.00
13.00	91.00	EMERGENCY	53,790	2,690	0	0	0	13.00
200.00			522,908	26,145	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	17.01	MENTAL HEALTH OVERHEAD	0	45,554	13,957	729,610	1.00
2.00	41.00	SUBPROVIDER - IRF	0	85,312	4,688	4,863	2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,271,828	3.00
4.00	54.00	DR. O	0	0	0	345,728	4.00
5.00	54.08	DR. G	0	22,223	0	48,510	5.00
6.00	60.00	DR. Q	0	158,828	0	60,272	6.00
7.00	65.00	DR. R	0	30,505	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	55,925	108,328	2,086,326	8.00
9.00	70.01	NEURODIAGNOSTICS	0	8,135	9,865	9,865	9.00
10.00	76.01	DR. S	0	34,165	5,835	5,835	10.00
11.00	75.00	ASC (NON-DIAGNOSTIC PART)	0	14,642	0	0	11.00
12.00	90.00	DR. L	0	13,829	13,109	1,155,428	12.00
13.00	91.00	EMERGENCY	0	53,790	33,634	5,397,950	13.00
200.00			0	522,908	189,416	11,116,215	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	21,340,380	21,340,380			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,120,607		1,120,607		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	32,471,914	110,857	5,827	32,588,598	4.00
4.01 00401	COMMUNICATIONS	251,929	0	0	78,505	330,434 4.01
4.02 00402	PURCHASING & RECEIVING	622,245	382,093	20,022	203,080	2,826 4.02
4.03 00403	REGISTRATION	1,014,187	0	0	300,941	2,983 4.03
4.04 00404	PATIENT ACCOUNTS	3,932,450	0	0	649,586	11,773 4.04
5.00 00500	ADMINISTRATIVE & GENERAL	19,242,634	1,038,861	60,459	2,951,600	21,820 5.00
7.00 00700	OPERATION OF PLANT	6,034,182	3,506,176	182,069	723,169	23,389 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	275,411	131,244	6,973	55,123	0 8.00
9.00 00900	HOUSEKEEPING	2,205,606	187,420	10,084	619,462	3,140 9.00
10.00 01000	DIETARY	120,644	0	0	106,790	4,238 10.00
11.00 01100	CAFETERIA	1,480,823	311,935	16,567	301,293	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,727,753	236,992	13,809	457,520	2,983 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	524,225	4,337	340	107,458	2,669 14.00
15.00 01500	PHARMACY	3,054,636	154,248	8,012	818,739	8,791 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,016,677	120,552	1,294	772,216	2,826 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
17.01 01701	MENTAL HEALTH OVERHEAD	1,606,708	85,785	4,558	617,276	26,215 17.01
23.00 02300	PARAMED PGRM-RADIOLOGY	160,047	0	0	62,116	0 23.00
23.01 02302	PARAMED PGRM-LAB	16,724	0	0	4,545	0 23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,519,457	1,816,804	100,120	1,657,837	27,000 30.00
31.00 03100	INTENSIVE CARE UNIT	3,739,556	666,363	35,403	1,080,631	11,616 31.00
40.00 04000	SUBPROVIDER - I/PF	773,732	327,562	17,548	199,707	0 40.00
41.00 04100	SUBPROVIDER - I/RF	3,283,107	479,766	29,367	938,975	11,459 41.00
43.00 04300	NURSERY	339,821	0	0	95,849	0 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	4,095,879	471,167	25,032	1,089,072	20,878 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
51.01 05101	ENDOSCOPY	1,235,991	304,981	16,203	309,287	3,767 51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,034,515	0	0	317,844	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,969,589	583,894	30,956	1,181,644	15,541 54.00
54.01 05401	RADIOLOGY-NON-CAMPUS	1,065,977	118,309	6,378	260,012	0 54.01
54.08 05408	RADIOLOGY-GSH BREAST CENTER	159,204	120,727	0	61,352	3,767 54.08
60.00 06000	LABORATORY	4,036,713	193,576	11,001	753,462	5,023 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	719,274	0	0	0	0 63.00
65.00 06500	RESPIRATORY THERAPY	2,067,102	140,017	7,520	609,437	4,238 65.00
66.00 06600	PHYSICAL THERAPY	2,856,269	379,202	10,976	844,864	1,570 66.00
69.00 06900	ELECTROCARDIOLOGY	3,119,269	427,353	21,334	1,488,167	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
70.01 07001	NEURODIAGNOSTICS	356,832	190,536	10,123	98,760	3,140 70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,177,994	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,003,500	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	13,933,510	0	0	239,256	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	1,822,400	0	0	363,181	0 75.00
76.00 03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0 76.00
76.01 03950	INPATIENT DIALYSIS	337,603	213,888	11,364	0	628 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	1,771,154	66,494	3,533	760,218	4,238 90.00
91.00 09100	EMERGENCY	4,472,822	421,970	21,873	1,279,572	8,006 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	120,060	9,820	522	21,085	0 96.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	886,091	95,903	6,437	151,301	3,610 116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	177,117,203	13,298,832	695,704	22,630,932	238,134 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1,099 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	33,914,159	3,315,269	165,669	8,937,203	86,648 192.00
194.00 07950	COMMUNITY HEALTH SERVICES	247,865	63,204	3,358	56,365	1,256 194.00
194.02 07952	MARKETING AND PUBLIC RELATIONS	949,024	34,020	1,159	45,019	942 194.02
194.03 07953	MH RESIDENTIAL	432,603	504,938	26,827	120,694	0 194.03
194.04 07954	UNUSED SPACE	0	2,543,905	145,030	0	0 194.04
194.05 07955	MOB	228,158	607,446	32,273	55,654	0 194.05
194.06 07956	FOUNDATION	421,435	14,007	871	38,957	314 194.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4.01	
194.07 07957 KNOX COUNTY HEALTH DEPT	0	117,437	6,239	0	2,041	194.07
194.08 07958 INDUSTRIAL HEALTH	21,378	0	0	5,897	0	194.08
194.09 07959 NRCC	2,775,448	841,322	43,477	697,877	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	216,107,273	21,340,380	1,120,607	32,588,598	330,434	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part I Date/Time Prepared: 5/26/2017 4:34 pm	
Cost Center Description			PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING	1,230,266					4.02
4.03	00403	REGISTRATION	549	1,318,660				4.03
4.04	00404	PATIENT ACCOUNTS	2,638	0	4,596,447			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	7,338	0	0	23,322,712	23,322,712	5.00
7.00	00700	OPERATION OF PLANT	12,056	0	0	10,481,041	1,267,975	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,121	0	0	471,872	57,086	8.00
9.00	00900	HOUSEKEEPING	7,504	0	0	3,033,216	366,952	9.00
10.00	01000	DIETARY	44,162	0	0	275,834	33,370	10.00
11.00	01100	CAFETERIA	0	0	0	2,110,618	255,338	11.00
13.00	01300	NURSING ADMINISTRATION	703	0	0	2,439,760	295,157	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,086	0	0	643,115	77,803	14.00
15.00	01500	PHARMACY	429,023	0	0	4,473,449	541,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	380	0	0	3,913,945	473,501	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	4,456	0	0	2,344,998	283,693	17.01
23.00	02300	PARAMED PGRM-RADIOLOGY	8	0	0	222,171	26,878	23.00
23.01	02302	PARAMED PGRM-LAB	66	0	0	21,335	2,581	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	58,001	84,548	294,701	10,558,468	1,277,342	30.00
31.00	03100	INTENSIVE CARE UNIT	11,251	43,383	151,214	5,739,417	694,343	31.00
40.00	04000	SUBPROVIDER - IPF	0	11,402	39,743	1,369,694	165,703	40.00
41.00	04100	SUBPROVIDER - IRF	4,051	21,957	76,532	4,845,214	586,164	41.00
43.00	04300	NURSERY	1,251	3,710	12,931	453,562	54,871	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	55,906	74,260	258,840	6,091,034	736,881	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	16,529	27,944	97,401	2,012,103	243,420	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,069	15,060	52,494	1,420,982	171,908	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,272	210,727	734,645	8,775,268	1,061,614	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	3,332	43,293	150,901	1,648,202	199,396	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	109	558	1,946	347,663	42,060	54.08
60.00	06000	LABORATORY	92,528	134,950	470,380	5,697,633	689,288	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	7,615	26,541	753,430	91,148	63.00
65.00	06500	RESPIRATORY THERAPY	9,381	37,614	131,107	3,006,416	363,710	65.00
66.00	06600	PHYSICAL THERAPY	28,530	75,414	262,861	4,459,686	539,524	66.00
69.00	06900	ELECTROCARDIOLOGY	39,340	95,195	331,811	5,522,469	668,097	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	842	12,351	43,051	715,635	86,576	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,411	60,689	9,256,094	1,119,784	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,078	30,175	105,178	3,248,931	393,049	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,462	161,701	563,626	14,973,555	1,811,471	73.00
75.00	07500	ASC (NON-DISTINCT PART)	34,711	51,880	180,834	2,453,006	296,760	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	200	2,635	9,184	575,502	69,623	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	21,009	15,214	53,030	2,694,890	326,022	90.00
91.00	09100	EMERGENCY	13,721	130,184	453,769	6,801,917	822,882	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	3,637	1,512	5,269	161,905	19,587	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	747	7,967	27,769	1,179,825	142,733	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,146,047	1,318,660	4,596,447	158,516,567	16,355,479	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,099	133	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60,453	0	0	46,479,401	5,623,009	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	967	0	0	373,015	45,127	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	19,406	0	0	1,049,570	126,975	194.02
194.03	07953	MH RESIDENTIAL	1,320	0	0	1,086,382	131,428	194.03
194.04	07954	UNUSED SPACE	0	0	0	2,688,935	325,302	194.04
194.05	07955	MOB	118	0	0	923,649	111,741	194.05
194.06	07956	FOUNDATION	1,866	0	0	477,450	57,761	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	125,717	15,209	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	27,275	3,300	194.08
194.09	07959	NRCC	89	0	0	4,358,213	527,248	194.09
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/26/2017 4:34 pm
Cost Center Description		PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL
202.00	TOTAL (sum lines 118-201)	1,230,266	1,318,660	4,596,447	216,107,273	23,322,712

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part I  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
4.01	00401	COMMUNICATIONS					4.01	
4.02	00402	PURCHASING & RECEIVING					4.02	
4.03	00403	REGISTRATION					4.03	
4.04	00404	PATIENT ACCOUNTS					4.04	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	11,749,016				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	94,587	623,545			8.00	
9.00	00900	HOUSEKEEPING	135,073	33,864	3,569,105		9.00	
10.00	01000	DIETARY	0	9,872	104,570	423,646	10.00	
11.00	01100	CAFETERIA	224,810	0	23,789	0	11.00	
13.00	01300	NURSING ADMINISTRATION	170,799	0	0	2,614,555	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	3,125	3,508	43,281	0	14.00	
15.00	01500	PHARMACY	111,165	0	42,156	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	86,881	0	18,724	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
17.01	01701	MENTAL HEALTH OVERHEAD	61,824	7,245	90,143	0	17.01	
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	0	0	6,371	23.00	
23.01	02302	PARAMED ED PGRM-LAB	0	0	0	13	23.01	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,309,360	216,986	1,027,186	181,176	30.00	
31.00	03100	INTENSIVE CARE UNIT	480,244	67,781	340,519	90,658	31.00	
40.00	04000	SUBPROVIDER - IPF	236,072	0	0	37,774	40.00	
41.00	04100	SUBPROVIDER - IRF	345,764	37,711	173,687	99,464	41.00	
43.00	04300	NURSERY	0	4,792	10,795	14,574	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	339,567	22,391	249,608	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00	
51.01	05101	ENDOSCOPY	219,798	13,007	52,848	0	51.01	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,870	10,897	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	420,809	52,803	169,543	0	54.00	
54.01	05401	RADIOLOGY-NON-CAMPUS	85,265	0	0	0	54.01	
54.08	05408	RADIOLOGY-GSH BREAST CENTER	87,007	0	0	5,022	54.08	
60.00	06000	LABORATORY	139,509	0	54,997	0	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	100,909	478	40,570	0	65.00	
66.00	06600	PHYSICAL THERAPY	273,288	25,307	84,823	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	307,991	11,846	127,336	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
70.01	07001	NEURODIAGNOSTICS	137,318	8,541	41,849	0	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,090	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	23,021	162,534	0	75.00	
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00	
76.01	03950	INPATIENT DIALYSIS	154,148	0	0	0	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	47,922	69	25,784	0	90.00	
91.00	09100	EMERGENCY	304,111	60,631	159,004	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				164,145	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	7,077	0	0	3,327	96.00	
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	87,312	0	25,938	0	116.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,971,735	605,723	3,080,581	423,646	2,032,843	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,389,293	17,822	453,275	0	192.00	
194.00	07950	COMMUNITY HEALTH SERVICES	45,551	0	17,292	0	194.00	
194.02	07952	MARKETING AND PUBLIC RELATIONS	24,518	0	6,241	0	194.02	
194.03	07953	MH RESIDENTIAL	363,906	0	0	30,066	194.03	
194.04	07954	UNUSED SPACE	1,833,377	0	0	0	194.04	
194.05	07955	MOB	437,782	0	0	6,651	194.05	
194.06	07956	FOUNDATION	10,095	0	0	4,153	194.06	
194.07	07957	KNOX COUNTY HEALTH DEPT	84,636	0	11,716	0	194.07	
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	194.08	
194.09	07959	NRCC	588,123	0	0	4,812	194.09	
200.00		Cross Foot Adjustments					200.00	
201.00		Negative Cost Centers	0	0	0	0	201.00	

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0042			Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/26/2017 4:34 pm	
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
202.00	TOTAL (sum lines 118-201)	11,749,016	623,545	3,569,105	423,646	2,614,555	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part I  
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Cost Center Description			NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,942,314					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	796,292				14.00
15.00	01500	PHARMACY	0	304,377	5,557,283			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	270	0	4,619,300		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	0	3,161	375	0	0	17.01
23.00	02300	PARAMED PGRM-RADIOLOGY	0	5	0	0	0	23.00
23.01	02302	PARAMED PGRM-LAB	0	47	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	802,309	41,147	14,746	852,526	0	30.00
31.00	03100	INTENSIVE CARE UNIT	468,075	7,981	5,047	165,286	0	31.00
40.00	04000	SUBPROVIDER - I/PF	204,845	0	0	52,195	0	40.00
41.00	04100	SUBPROVIDER - I/RF	444,544	2,873	2,317	260,977	0	41.00
43.00	04300	NURSERY	34,390	888	167	34,797	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	200,862	39,661	31,742	173,985	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	11,726	911	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	115,815	758	557	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,245	47,062	0	0	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	2,364	16,747	0	0	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	77	22	0	0	54.08
60.00	06000	LABORATORY	0	65,641	1,174	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	6,655	722	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,024	981	269,677	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	27,909	15,800	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	597	16	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	78,091	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	53,535	4,764,100	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	24,624	6,034	643,744	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	142	1,755	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	14,904	194,503	0	0	90.00
91.00	09100	EMERGENCY	540,035	9,734	6,750	2,166,113	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,580	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	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	131,439	530	81	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,942,314	736,546	5,111,609	4,619,300	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	42,886	438,759	0	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	686	6,473	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	13,767	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	936	124	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	84	318	0	0	194.05
194.06	07956	FOUNDATION	0	1,324	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	NRCC	0	63	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0042			Period: From 01/01/2016 To 12/31/2016		Worksheet B Part I Date/Time Prepared: 5/26/2017 4:34 pm	
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		13.00	14.00	15.00	16.00	17.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,942,314	796,292	5,557,283	4,619,300		0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/26/2017 4:34 pm
Cost Center	Description	MENTAL HEALTH OVERHEAD	PARAMED ED PGRM-RADIOLOGY	PARAMED ED PGRM-LAB	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
		17.01	23.00	23.01	24.00	25.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
4.01	00401	COMMUNICATIONS				4.01
4.02	00402	PURCHASING & RECEIVING				4.02
4.03	00403	REGISTRATION				4.03
4.04	00404	PATIENT ACCOUNTS				4.04
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	MENTAL HEALTH OVERHEAD	3,052,093			17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	255,425		23.00
23.01	02302	PARAMED ED PGRM-LAB	0		23,976	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	1,251,391	0	0	17,776,502
31.00	03100	INTENSIVE CARE UNIT	0	0	0	8,201,624
40.00	04000	SUBPROVIDER - IPF	263,298	0	0	2,329,581
41.00	04100	SUBPROVIDER - IRF	0	0	0	6,933,836
43.00	04300	NURSERY	0	0	0	619,289
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0	0	7,957,588
51.00	05100	RECOVERY ROOM	0	0	0	0
51.01	05101	ENDOSCOPY	0	0	0	2,587,806
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,761,989
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	255,425	0	10,949,471
54.01	05401	RADIOLOGY-NON-CAMPUS	0	0	0	1,977,982
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	0	0	481,851
60.00	06000	LABORATORY	0	0	23,976	6,785,572
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	844,578
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,585,572
66.00	06600	PHYSICAL THERAPY	0	0	0	5,735,159
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,771,441
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
70.01	07001	NEURODIAGNOSTICS	0	0	0	1,004,756
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,375,878
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,720,071
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,608,751
75.00	07500	ASC (NON-DISTINCT PART)	1,198,024	0	0	4,851,990
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0
76.01	03950	INPATIENT DIALYSIS	0	0	0	801,170
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	3,359,041
91.00	09100	EMERGENCY	0	0	0	11,035,322
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	194,476
101.00	10100	HOME HEALTH AGENCY	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE	0	0	0	0
116.00	11600	HOSPICE	0	0	0	1,587,899
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,712,713	255,425	23,976	143,839,195
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,232
192.00	19200	PHYSICIANS' PRIVATE OFFICES	339,380	0	0	56,305,428
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	496,163
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	1,227,479
194.03	07953	MH RESIDENTIAL	0	0	0	1,612,842
194.04	07954	UNUSED SPACE	0	0	0	4,847,614
194.05	07955	MOB	0	0	0	1,480,225
194.06	07956	FOUNDATION	0	0	0	550,783
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	237,278
194.08	07958	INDUSTRIAL HEALTH	0	0	0	30,575

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0042			Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/26/2017 4:34 pm	
Cost Center Description		MENTAL HEALTH OVERHEAD	PARAMED ED PGRM-RADIOLOGY	PARAMED ED PGRM-LAB	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		17.01	23.00	23.01	24.00	25.00	
194.09	07959 NRCC	0	0	0	5,478,459	0	194.09
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,052,093	255,425	23,976	216,107,273	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part I  
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
4.01	00401 COMMUNICATIONS		4.01
4.02	00402 PURCHASING & RECEIVING		4.02
4.03	00403 REGISTRATION		4.03
4.04	00404 PATIENT ACCOUNTS		4.04
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
17.01	01701 MENTAL HEALTH OVERHEAD		17.01
23.00	02300 PARAMED ED PGRM-RADIOLOGY		23.00
23.01	02302 PARAMED ED PGRM-LAB		23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	17,776,502	30.00
31.00	03100 INTENSIVE CARE UNIT	8,201,624	31.00
40.00	04000 SUBPROVIDER - IPF	2,329,581	40.00
41.00	04100 SUBPROVIDER - IRF	6,933,836	41.00
43.00	04300 NURSERY	619,289	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	7,957,588	50.00
51.00	05100 RECOVERY ROOM	0	51.00
51.01	05101 ENDOSCOPY	2,587,806	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,761,989	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,949,471	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	1,977,982	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	481,851	54.08
60.00	06000 LABORATORY	6,785,572	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	844,578	63.00
65.00	06500 RESPIRATORY THERAPY	3,585,572	65.00
66.00	06600 PHYSICAL THERAPY	5,735,159	66.00
69.00	06900 ELECTROCARDIOLOGY	6,771,441	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
70.01	07001 NEURODIAGNOSTICS	1,004,756	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,375,878	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,720,071	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,608,751	73.00
75.00	07500 ASC (NON-DISTINCT PART)	4,851,990	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	76.00
76.01	03950 INPATIENT DIALYSIS	801,170	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	3,359,041	90.00
91.00	09100 EMERGENCY	11,035,322	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	194,476	96.00
101.00	10100 HOME HEALTH AGENCY	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	1,587,899	116.00
118.00			118.00
	SUBTOTALS (SUM OF LINES 1-117)	143,839,195	
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,232	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	56,305,428	192.00
194.00	07950 COMMUNITY HEALTH SERVICES	496,163	194.00
194.02	07952 MARKETING AND PUBLIC RELATIONS	1,227,479	194.02
194.03	07953 MH RESIDENTIAL	1,612,842	194.03
194.04	07954 UNUSED SPACE	4,847,614	194.04
194.05	07955 MOB	1,480,225	194.05
194.06	07956 FOUNDATION	550,783	194.06
194.07	07957 KNOX COUNTY HEALTH DEPT	237,278	194.07
194.08	07958 INDUSTRIAL HEALTH	30,575	194.08
194.09	07959 NRCC	5,478,459	194.09
200.00		0	200.00
	Cross Foot Adjustments	0	
201.00		0	201.00
	Negative Cost Centers	0	
202.00		216,107,273	202.00
	TOTAL (sum lines 118-201)		

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period: From 01/01/2016 To 12/31/2016

Worksheet B Part II Date/Time Prepared: 5/26/2017 4:34 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	110,857	5,827	116,684	4.00
4.01	00401	COMMUNICATIONS	0	0	0	281	4.01
4.02	00402	PURCHASING & RECEIVING	0	382,093	20,022	402,115	4.02
4.03	00403	REGISTRATION	0	0	0	1,077	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	0	2,326	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,038,861	60,459	1,099,320	5.00
7.00	00700	OPERATION OF PLANT	0	3,506,176	182,069	3,688,245	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	131,244	6,973	138,217	8.00
9.00	00900	HOUSEKEEPING	0	187,420	10,084	197,504	9.00
10.00	01000	DIETARY	0	0	0	382	10.00
11.00	01100	CAFETERIA	0	311,935	16,567	328,502	11.00
13.00	01300	NURSING ADMINISTRATION	0	236,992	13,809	250,801	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,337	340	4,677	14.00
15.00	01500	PHARMACY	0	154,248	8,012	162,260	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	120,552	1,294	121,846	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	0	85,785	4,558	90,343	17.01
23.00	02300	PARAMED PGRM-RADIOLOGY	0	0	0	222	23.00
23.01	02302	PARAMED PGRM-LAB	0	0	0	16	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	1,816,804	100,120	1,916,924	30.00
31.00	03100	INTENSIVE CARE UNIT	0	666,363	35,403	701,766	31.00
40.00	04000	SUBPROVIDER - IPF	0	327,562	17,548	345,110	40.00
41.00	04100	SUBPROVIDER - IRF	0	479,766	29,367	509,133	41.00
43.00	04300	NURSERY	0	0	0	343	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	471,167	25,032	496,199	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	304,981	16,203	321,184	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,138	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	583,894	30,956	614,850	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	118,309	6,378	124,687	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	120,727	0	120,727	54.08
60.00	06000	LABORATORY	0	193,576	11,001	204,577	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	140,017	7,520	147,537	65.00
66.00	06600	PHYSICAL THERAPY	0	379,202	10,976	390,178	66.00
69.00	06900	ELECTROCARDIOLOGY	0	427,353	21,334	448,687	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	190,536	10,123	200,659	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	857	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	1,300	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	213,888	11,364	225,252	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	66,494	3,533	70,027	90.00
91.00	09100	EMERGENCY	0	421,970	21,873	443,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	9,820	522	10,342	96.00
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	95,903	6,437	102,340	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	13,298,832	695,704	13,994,536	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,315,269	165,669	3,480,938	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	63,204	3,358	66,562	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	34,020	1,159	35,179	194.02
194.03	07953	MH RESIDENTIAL	0	504,938	26,827	531,765	194.03
194.04	07954	UNUSED SPACE	0	2,543,905	145,030	2,688,935	194.04
194.05	07955	MOB	0	607,446	32,273	639,719	194.05
194.06	07956	FOUNDATION	0	14,007	871	14,878	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	117,437	6,239	123,676	194.07

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part II  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	21	194.08
194.09 07959 NRCC	0	841,322	43,477	884,799	2,499	194.09
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	21,340,380	1,120,607	22,460,987	116,684	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/26/2017 4:34 pm		
Cost Center Description			COMMUNICATIONS 4.01	PURCHASING & RECEIVING 4.02	REGISTRATION 4.03	PATIENT ACCOUNTS 4.04	ADMINISTRATIVE & GENERAL 5.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS	281				4.01
4.02	00402	PURCHASING & RECEIVING	2	402,844			4.02
4.03	00403	REGISTRATION	3	180	1,260		4.03
4.04	00404	PATIENT ACCOUNTS	10	864	0	3,200	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	19	2,403	0	0	1,112,309
7.00	00700	OPERATION OF PLANT	20	3,948	0	0	60,476
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,022	0	0	2,723
9.00	00900	HOUSEKEEPING	3	2,457	0	0	17,502
10.00	01000	DIETARY	4	14,461	0	0	1,592
11.00	01100	CAFETERIA	0	0	0	0	12,178
13.00	01300	NURSING ADMINISTRATION	3	230	0	0	14,077
14.00	01400	CENTRAL SERVICES & SUPPLY	2	1,338	0	0	3,711
15.00	01500	PHARMACY	7	140,479	0	0	25,812
16.00	01600	MEDICAL RECORDS & LIBRARY	2	124	0	0	22,583
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	MENTAL HEALTH OVERHEAD	22	1,459	0	0	13,531
23.00	02300	PARAMED ED PGRM-RADIOLOGY	0	2	0	0	1,282
23.01	02302	PARAMED ED PGRM-LAB	0	22	0	0	123
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	23	18,992	69	206	60,922
31.00	03100	INTENSIVE CARE UNIT	10	3,684	35	106	33,116
40.00	04000	SUBPROVIDER - IPF	0	0	9	28	7,903
41.00	04100	SUBPROVIDER - IRF	10	1,326	18	53	27,957
43.00	04300	NURSERY	0	410	3	9	2,617
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	18	18,306	60	181	35,145
51.00	05100	RECOVERY ROOM	0	0	0	0	0
51.01	05101	ENDOSCOPY	3	5,412	23	68	11,610
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	350	12	37	8,199
54.00	05400	RADIOLOGY-DIAGNOSTIC	13	15,807	364	503	50,633
54.01	05401	RADIOLOGY-NON-CAMPUS	0	1,091	35	105	9,510
54.08	05408	RADIOLOGY-GSH BREAST CENTER	3	36	0	1	2,006
60.00	06000	LABORATORY	4	30,298	109	328	32,875
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	6	19	4,347
65.00	06500	RESPIRATORY THERAPY	4	3,072	31	92	17,347
66.00	06600	PHYSICAL THERAPY	1	9,342	61	184	25,732
69.00	06900	ELECTROCARDIOLOGY	0	12,882	77	232	31,865
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01	07001	NEURODIAGNOSTICS	3	276	10	30	4,129
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	14	42	53,408
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	36,045	24	73	18,746
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,710	131	394	86,397
75.00	07500	ASC (NON-DISTINCT PART)	0	11,366	42	126	14,154
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0
76.01	03950	INPATIENT DIALYSIS	1	65	2	6	3,321
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	4	6,879	12	37	15,550
91.00	09100	EMERGENCY	7	4,493	106	317	39,247
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,191	1	4	934
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	3	245	6	19	6,808
118.00		SUBTOTALS (SUM OF LINES 1-117)	204	375,267	1,260	3,200	780,068
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0	0	0	6
192.00	19200	PHYSICIANS' PRIVATE OFFICES	72	19,795	0	0	268,131
194.00	07950	COMMUNITY HEALTH SERVICES	1	317	0	0	2,152
194.02	07952	MARKETING AND PUBLIC RELATIONS	1	6,354	0	0	6,056
194.03	07953	MH RESIDENTIAL	0	432	0	0	6,268
194.04	07954	UNUSED SPACE	0	0	0	0	15,515
194.05	07955	MOB	0	39	0	0	5,329
194.06	07956	FOUNDATION	0	611	0	0	2,755
194.07	07957	KNOX COUNTY HEALTH DEPT	2	0	0	0	725
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	157
194.09	07959	NRCC	0	29	0	0	25,147
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0042			Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/26/2017 4:34 pm
Cost Center Description		COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL
202.00	TOTAL (sum lines 118-201)	281	402,844	1,260	3,200	1,112,309

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/26/2017 4:34 pm	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	3,755,278					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,232	172,391				8.00
9.00	00900	HOUSEKEEPING	43,173	9,363	272,220			9.00
10.00	01000	DIETARY	0	2,729	7,976	27,144		10.00
11.00	01100	CAFETERIA	71,855	0	1,814	0	415,428	11.00
13.00	01300	NURSING ADMINISTRATION	54,591	0	0	0	5,815	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	999	970	3,301	0	4,045	14.00
15.00	01500	PHARMACY	35,531	0	3,215	0	13,497	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,769	0	1,428	0	20,017	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	19,761	2,003	6,875	0	41,415	17.01
23.00	02300	PARAMED PGRM-RADIOLOGY	0	0	0	0	1,012	23.00
23.01	02302	PARAMED PGRM-LAB	0	0	0	0	2	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	418,504	59,989	78,345	11,608	38,748	30.00
31.00	03100	INTENSIVE CARE UNIT	153,498	18,739	25,972	5,809	22,606	31.00
40.00	04000	SUBPROVIDER - IPF	75,454	0	0	2,420	0	40.00
41.00	04100	SUBPROVIDER - IRF	110,515	10,426	13,247	6,373	21,469	41.00
43.00	04300	NURSERY	0	1,325	823	934	1,661	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	108,534	6,191	19,038	0	11,417	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	70,253	3,596	4,031	0	5,401	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,623	831	0	5,593	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,501	14,598	12,931	0	21,085	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	27,253	0	0	0	4,132	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	27,810	0	0	0	798	54.08
60.00	06000	LABORATORY	44,591	0	4,195	0	18,011	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	32,253	132	3,094	0	10,505	65.00
66.00	06600	PHYSICAL THERAPY	87,350	6,997	6,470	0	12,687	66.00
69.00	06900	ELECTROCARDIOLOGY	98,441	3,275	9,712	0	14,299	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	43,890	2,361	3,192	0	2,260	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	968	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	6,365	12,397	0	7,030	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	49,270	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	15,317	19	1,967	0	8,730	90.00
91.00	09100	EMERGENCY	97,201	16,763	12,127	0	26,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,262	0	0	0	529	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	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	27,907	0	1,978	0	3,184	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,908,715	167,464	234,959	27,144	322,997	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	763,678	4,927	34,572	0	82,880	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	14,559	0	1,319	0	1,274	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	7,837	0	476	0	1,018	194.02
194.03	07953	MH RESIDENTIAL	116,313	0	0	0	4,777	194.03
194.04	07954	UNUSED SPACE	585,993	0	0	0	0	194.04
194.05	07955	MOB	139,926	0	0	0	1,057	194.05
194.06	07956	FOUNDATION	3,226	0	0	0	660	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	27,052	0	894	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	NRCC	187,979	0	0	0	765	194.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0042			Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/26/2017 4:34 pm	
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
202.00	TOTAL (sum lines 118-201)	3,755,278	172,391	272,220	27,144	415,428	202.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/26/2017 4:34 pm
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Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
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	327,155					13.00
14.00	01400	0	19,428				14.00
15.00	01500	0	7,433	391,165			15.00
16.00	01600	0	7	0	196,541		16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	0	77	26	0	0	17.01
23.00	02300	0	0	0	0	0	23.00
23.01	02302	0	1	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	89,208	1,003	1,038	36,273	0	30.00
31.00	03100	52,045	195	355	7,033	0	31.00
40.00	04000	22,777	0	0	2,221	0	40.00
41.00	04100	49,429	70	163	11,104	0	41.00
43.00	04300	3,824	22	12	1,481	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	22,334	967	2,234	7,403	0	50.00
51.00	05100	0	0	0	0	0	51.00
51.01	05101	0	286	64	0	0	51.01
52.00	05200	12,877	18	39	0	0	52.00
54.00	05400	0	835	3,313	0	0	54.00
54.01	05401	0	58	1,179	0	0	54.01
54.08	05408	0	2	2	0	0	54.08
60.00	06000	0	1,601	83	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	162	51	0	0	65.00
66.00	06600	0	49	69	11,474	0	66.00
69.00	06900	0	681	1,112	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	0	15	1	0	0	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	1,904	0	0	0	72.00
73.00	07300	0	1,305	335,332	0	0	73.00
75.00	07500	0	600	425	27,390	0	75.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	3	124	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	363	13,691	0	0	90.00
91.00	09100	60,046	237	475	92,162	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	63	0	0	0	96.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	14,615	13	6	0	0	116.00
118.00		327,155	17,970	359,794	196,541	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	1,046	30,884	0	0	192.00
194.00	07950	0	17	456	0	0	194.00
194.02	07952	0	336	0	0	0	194.02
194.03	07953	0	23	9	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	2	22	0	0	194.05
194.06	07956	0	32	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	2	0	0	0	194.09
200.00							200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0042			Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/26/2017 4:34 pm	
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		13.00	14.00	15.00	16.00	17.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	327,155	19,428	391,165	196,541		0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/26/2017 4:34 pm		
Cost Center	Description	MENTAL HEALTH OVERHEAD	PARAMED ED PGRM-RADIOLOGY	PARAMED ED PGRM-LAB	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
		17.01	23.00	23.01	24.00	25.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
4.01	00401					4.01
4.02	00402					4.02
4.03	00403					4.03
4.04	00404					4.04
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
17.01	01701	177,722				17.01
23.00	02300		2,518			23.00
23.01	02302			164		23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	72,853			2,810,640	30.00
31.00	03100				1,028,838	31.00
40.00	04000	15,334			471,971	40.00
41.00	04100				764,655	41.00
43.00	04300				13,464	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0			731,926	50.00
51.00	05100	0			0	51.00
51.01	05101	0			423,038	51.01
52.00	05200	0			30,717	52.00
54.00	05400	0			873,664	54.00
54.01	05401	0			168,981	54.01
54.08	05408	0			151,605	54.08
60.00	06000	0			339,370	60.00
63.00	06300	0			4,372	63.00
65.00	06500	0			216,462	65.00
66.00	06600	0			553,619	66.00
69.00	06900	0			626,591	69.00
70.00	07000	0			0	70.00
70.01	07001	0			257,180	70.01
71.00	07100	0			53,464	71.00
72.00	07200	0			56,792	72.00
73.00	07300	0			450,094	73.00
75.00	07500	69,770			150,965	75.00
76.00	03020	0			0	76.00
76.01	03950	0			278,044	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0			135,318	90.00
91.00	09100	0			797,686	91.00
92.00	09200	0			0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	0			15,401	96.00
101.00	10100	0			0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	0			0	113.00
116.00	11600	0			157,666	116.00
118.00		157,957	0	0	11,562,523	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0			7	190.00
192.00	19200	19,765			4,738,695	192.00
194.00	07950	0			86,859	194.00
194.02	07952	0			57,418	194.02
194.03	07953	0			660,019	194.03
194.04	07954	0			3,290,443	194.04
194.05	07955	0			786,293	194.05
194.06	07956	0			22,301	194.06
194.07	07957	0			152,349	194.07
194.08	07958	0			178	194.08

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part II  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description			MENTAL HEALTH OVERHEAD	PARAMED ED PGRM-RADIOLOGY	PARAMED ED PGRM-LAB	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.01	23.00	23.01	24.00	25.00	
194.09	07959	NRCC	0			1,101,220		0194.09
200.00		Cross Foot Adjustments		2,518	164	2,682		0200.00
201.00		Negative Cost Centers	0	0	0	0		0201.00
202.00		TOTAL (sum lines 118-201)	177,722	2,518	164	22,460,987		0202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part II  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
4.01	00401	COMMUNICATIONS	4.01
4.02	00402	PURCHASING & RECEIVING	4.02
4.03	00403	REGISTRATION	4.03
4.04	00404	PATIENT ACCOUNTS	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
17.01	01701	MENTAL HEALTH OVERHEAD	17.01
23.00	02300	PARAMED ED PGRM-RADIOLOGY	23.00
23.01	02302	PARAMED ED PGRM-LAB	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
51.01	05101	ENDOSCOPY	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	54.08
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
70.01	07001	NEURODIAGNOSTICS	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	76.00
76.01	03950	INPATIENT DIALYSIS	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
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
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	194.02
194.03	07953	MH RESIDENTIAL	194.03
194.04	07954	UNUSED SPACE	194.04
194.05	07955	MOB	194.05
194.06	07956	FOUNDATION	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	194.07
194.08	07958	INDUSTRIAL HEALTH	194.08
194.09	07959	NRCC	194.09
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

Period: From 01/01/2016 To 12/31/2016

Worksheet B-1

Date/Time Prepared: 5/26/2017 4:34 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	856,256				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		846,308			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,448	4,401	104,081,243		4.00
4.01 00401	COMMUNICATIONS	0	0	250,728	2,105	4.01
4.02 00402	PURCHASING & RECEIVING	15,331	15,121	648,596	18	33,568,309
4.03 00403	REGISTRATION	0	0	961,144	19	14,987
4.04 00404	PATIENT ACCOUNTS	0	0	2,074,646	75	71,975
5.00 00500	ADMINISTRATIVE & GENERAL	41,683	45,660	9,426,810	139	200,231
7.00 00700	OPERATION OF PLANT	140,681	137,503	2,309,654	149	328,944
8.00 00800	LAUNDRY & LINEN SERVICE	5,266	5,266	176,053	0	85,156
9.00 00900	HOUSEKEEPING	7,520	7,616	1,978,435	20	204,760
10.00 01000	DIETARY	0	0	341,067	27	1,204,977
11.00 01100	CAFETERIA	12,516	12,512	962,268	0	0
13.00 01300	NURSING ADMINISTRATION	9,509	10,429	1,461,227	19	19,171
14.00 01400	CENTRAL SERVICES & SUPPLY	174	257	343,198	17	111,494
15.00 01500	PHARMACY	6,189	6,051	2,614,885	56	11,706,233
16.00 01600	MEDICAL RECORDS & LIBRARY	4,837	977	2,466,302	18	10,370
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
17.01 01701	MENTAL HEALTH OVERHEAD	3,442	3,442	1,971,454	167	121,589
23.00 02300	PARAMED PGRM-RADIOLOGY	0	0	198,386	0	208
23.01 02301	PARAMED PGRM-LAB	0	0	14,515	0	1,801
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	72,897	75,613	5,294,795	172	1,582,558
31.00 03100	INTENSIVE CARE UNIT	26,737	26,737	3,451,316	74	306,973
40.00 04000	SUBPROVIDER - I/PF	13,143	13,253	637,824	0	0
41.00 04100	SUBPROVIDER - I/RF	19,250	22,179	2,998,895	73	110,519
43.00 04300	NURSERY	0	0	306,123	0	34,139
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	18,905	18,905	3,478,275	133	1,525,405
51.00 05100	RECOVERY ROOM	0	0	0	0	0
51.01 05101	ENDOSCOPY	12,237	12,237	987,801	24	450,998
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	1,015,128	0	29,157
54.00 05400	RADIOLOGY-DIAGNOSTIC	23,428	23,379	3,773,930	99	1,317,107
54.01 05401	RADIOLOGY-NON-CAMPUS	4,747	4,817	830,426	0	90,921
54.08 05408	RADIOLOGY-GSH BREAST CENTER	4,844	0	195,947	24	2,978
60.00 06000	LABORATORY	7,767	8,308	2,406,404	32	2,524,652
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	5,618	5,679	1,946,419	27	255,970
66.00 06600	PHYSICAL THERAPY	15,215	8,289	2,698,322	10	778,433
69.00 06900	ELECTROCARDIOLOGY	17,147	16,112	4,752,902	0	1,073,409
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01 07001	NEURODIAGNOSTICS	7,645	7,645	315,419	20	22,978
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,003,500
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	764,136	0	2,059,003
75.00 07500	ASC (NON-DISTINCT PART)	0	0	1,159,926	0	947,095
76.00 03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0
76.01 03950	INPATIENT DIALYSIS	8,582	8,582	0	4	5,455
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	2,668	2,668	2,427,981	27	573,232
91.00 09100	EMERGENCY	16,931	16,519	4,086,692	51	374,383
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	394	394	67,342	0	99,230
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	3,848	4,861	483,224	23	20,388
118.00	SUBTOTALS (SUM OF LINES 1-117)	533,599	525,412	72,278,595	1,517	31,270,379
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	133,021	125,117	28,543,499	552	1,649,473
194.00 07950	COMMUNITY HEALTH SERVICES	2,536	2,536	180,017	8	26,392
194.02 07952	MARKETING AND PUBLIC RELATIONS	1,365	875	143,780	6	529,484
194.03 07953	MH RESIDENTIAL	20,260	20,260	385,473	0	36,014
194.04 07954	UNUSED SPACE	102,071	109,530	0	0	0
194.05 07955	MOB	24,373	24,373	177,746	0	3,212
194.06 07956	FOUNDATION	562	658	124,422	2	50,919

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B-1  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
194.0707957 KNOX COUNTY HEALTH DEPT	4,712	4,712	0	13	0	194.07
194.0807958 INDUSTRIAL HEALTH	0	0	18,835	0	0	194.08
194.0907959 NRCC	33,757	32,835	2,228,876	0	2,436	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	21,340,380	1,120,607	32,588,598	330,434	1,230,266	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	24.922897	1.324112	0.313107	156.975772	0.036650	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			116,684	281	402,844	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001121	0.133492	0.012001	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet B-1	
Date/Time Prepared: 5/26/2017 4:34 pm							
Cost Center	Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		4.03	4.04	5A	5.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION	534,978,942				4.03
4.04	00404	PATIENT ACCOUNTS	0	534,978,942			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	-23,322,712	192,784,561	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	10,481,041	654,112
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	471,872	5,266
9.00	00900	HOUSEKEEPING	0	0	0	3,033,216	7,520
10.00	01000	DIETARY	0	0	0	275,834	0
11.00	01100	CAFETERIA	0	0	0	2,110,618	12,516
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,439,760	9,509
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	643,115	174
15.00	01500	PHARMACY	0	0	0	4,473,449	6,189
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,913,945	4,837
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	MENTAL HEALTH OVERHEAD	0	0	0	2,344,998	3,442
23.00	02300	PARAMEDICAL PGRM-RADIOLOGY	0	0	0	222,171	0
23.01	02302	PARAMEDICAL PGRM-LAB	0	0	0	21,335	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	34,299,512	34,299,512	0	10,558,468	72,897
31.00	03100	INTENSIVE CARE UNIT	17,599,450	17,599,450	0	5,739,417	26,737
40.00	04000	SUBPROVIDER - IPF	4,625,587	4,625,587	0	1,369,694	13,143
41.00	04100	SUBPROVIDER - IRF	8,907,398	8,907,398	0	4,845,214	19,250
43.00	04300	NURSERY	1,504,994	1,504,994	0	453,562	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	30,125,664	30,125,664	0	6,091,034	18,905
51.00	05100	RECOVERY ROOM	0	0	0	0	0
51.01	05101	ENDOSCOPY	11,336,211	11,336,211	0	2,012,103	12,237
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,109,658	6,109,658	0	1,420,982	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,513,953	85,513,953	0	8,775,268	23,428
54.01	05401	RADIOLOGY-NON-CAMPUS	17,562,995	17,562,995	0	1,648,202	4,747
54.08	05408	RADIOLOGY-GSH BREAST CENTER	226,475	226,475	0	347,663	4,844
60.00	06000	LABORATORY	54,746,270	54,746,270	0	5,697,633	7,767
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,089,048	3,089,048	0	753,430	0
65.00	06500	RESPIRATORY THERAPY	15,259,166	15,259,166	0	3,006,416	5,618
66.00	06600	PHYSICAL THERAPY	30,593,723	30,593,723	0	4,459,686	15,215
69.00	06900	ELECTROCARDIOLOGY	38,618,594	38,618,594	0	5,522,469	17,147
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01	07001	NEURODIAGNOSTICS	5,010,630	5,010,630	0	715,635	7,645
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,063,417	7,063,417	0	9,256,094	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,241,393	12,241,393	0	3,248,931	0
73.00	07300	DRUGS CHARGED TO PATIENTS	65,598,938	65,598,938	0	14,973,555	0
75.00	07500	ASC (NON-DISTINCT PART)	21,046,762	21,046,762	0	2,453,006	0
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	0
76.01	03950	INPATIENT DIALYSIS	1,068,935	1,068,935	0	575,502	8,582
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	6,171,971	6,171,971	0	2,694,890	2,668
91.00	09100	EMERGENCY	52,812,968	52,812,968	0	6,801,917	16,931
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	613,252	613,252	0	161,905	394
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	3,231,978	3,231,978	0	1,179,825	4,861
118.00		SUBTOTALS (SUM OF LINES 1-117)	534,978,942	534,978,942	-23,322,712	135,193,855	332,469
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,099	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	46,479,401	133,021
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	373,015	2,536
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	1,049,570	1,365
194.03	07953	MH RESIDENTIAL	0	0	0	1,086,382	20,260
194.04	07954	UNUSED SPACE	0	0	0	2,688,935	102,071
194.05	07955	MOB	0	0	0	923,649	24,373
194.06	07956	FOUNDATION	0	0	0	477,450	562
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	125,717	4,712
194.08	07958	INDUSTRIAL HEALTH	0	0	0	27,275	0
194.09	07959	NRCC	0	0	0	4,358,213	32,743

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B-1  
Date/Time Prepared:  
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Cost Center Description		REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		4.03	4.04	5A	5.00	7.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,318,660	4,596,447		23,322,712	11,749,016	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.002465	0.008592		0.120978	17.961780	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,260	3,200		1,112,309	3,755,278	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000002	0.000006		0.005770	5.741032	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

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Cost Center Description		LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATIVE (DIRECT NURSING)	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
5.00	00500						5.00
7.00	00700						7.00
8.00	00800	1,075,114					8.00
9.00	00900	58,389	69,764				9.00
10.00	01000	17,022	2,044	33,197			10.00
11.00	01100	0	465	0	2,593,589		11.00
13.00	01300	0	0	0	36,305	887,154	13.00
14.00	01400	6,048	846	0	25,256	0	14.00
15.00	01500	0	824	0	84,266	0	15.00
16.00	01600	0	366	0	124,969	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	12,491	1,762	0	258,564	0	17.01
23.00	02300	0	0	0	6,320	0	23.00
23.01	02302	0	0	0	13	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	374,126	20,078	14,197	241,909	241,909	30.00
31.00	03100	116,867	6,656	7,104	141,132	141,132	31.00
40.00	04000	0	0	2,960	0	61,764	40.00
41.00	04100	65,021	3,395	7,794	134,037	134,037	41.00
43.00	04300	8,263	211	1,142	10,369	10,369	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	38,607	4,879	0	71,281	60,563	50.00
51.00	05100	0	0	0	0	0	51.00
51.01	05101	22,426	1,033	0	33,720	0	51.01
52.00	05200	10,121	213	0	34,920	34,920	52.00
54.00	05400	91,043	3,314	0	131,638	0	54.00
54.01	05401	0	0	0	25,799	0	54.01
54.08	05408	0	0	0	4,982	0	54.08
60.00	06000	0	1,075	0	112,445	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	824	793	0	65,582	0	65.00
66.00	06600	43,635	1,658	0	79,209	0	66.00
69.00	06900	20,424	2,489	0	89,271	0	69.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	14,727	818	0	14,110	0	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	6,041	0	73.00
75.00	07500	39,693	3,177	0	43,888	0	75.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	119	504	0	54,506	0	90.00
91.00	09100	104,540	3,108	0	162,829	162,829	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	3,300	0	96.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	0	507	0	19,880	39,631	116.00
118.00		1,044,386	60,215	33,197	2,016,541	887,154	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	30,728	8,860	0	517,420	0	192.00
194.00	07950	0	338	0	7,955	0	194.00
194.02	07952	0	122	0	6,357	0	194.02
194.03	07953	0	0	0	29,825	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	6,598	0	194.05
194.06	07956	0	0	0	4,120	0	194.06
194.07	07957	0	229	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B-1

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Cost Center Description			LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
194.09	07959	NRCC	0	0	0	4,773	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	623,545	3,569,105	423,646	2,614,555	2,942,314	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.579980	51.159696	12.761575	1.008084	3.316576	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	172,391	272,220	27,144	415,428	327,155	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.160347	3.902012	0.817664	0.160175	0.368769	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B-1  
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Cost Center Description		CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED RECUISES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	MENTAL HEALTH OVERHEAD (CHARGES)	
		14.00	15.00	16.00	17.00	17.01	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
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	30,626,045					14.00
15.00	01500	11,706,233	13,363,748				15.00
16.00	01600	10,370	0	531			16.00
17.00	01700	0	0	0	0		17.00
17.01	01701	121,589	901	0	0	53,618,990	17.01
23.00	02300	208	0	0	0	0	23.00
23.01	02302	1,801	0	0	0	0	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,582,558	35,459	98	0	21,984,453	30.00
31.00	03100	306,973	12,136	19	0	0	31.00
40.00	04000	0	0	6	0	4,625,587	40.00
41.00	04100	110,519	5,571	30	0	0	41.00
43.00	04300	34,139	401	4	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,525,405	76,330	20	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
51.01	05101	450,998	2,191	0	0	0	51.01
52.00	05200	29,157	1,340	0	0	0	52.00
54.00	05400	1,317,107	113,171	0	0	0	54.00
54.01	05401	90,921	40,271	0	0	0	54.01
54.08	05408	2,978	54	0	0	0	54.08
60.00	06000	2,524,652	2,822	0	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	255,970	1,737	0	0	0	65.00
66.00	06600	77,843	2,359	31	0	0	66.00
69.00	06900	1,073,409	37,995	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	22,978	38	0	0	0	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	3,003,500	0	0	0	0	72.00
73.00	07300	2,059,024	11,456,365	0	0	0	73.00
75.00	07500	947,095	14,509	74	0	21,046,762	75.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	5,455	4,221	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	573,232	467,727	0	0	0	90.00
91.00	09100	374,383	16,232	249	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	99,230	0	0	0	0	96.00
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	20,388	195	0	0	0	116.00
118.00		28,328,115	12,292,025	531	0	47,656,802	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	1,649,473	1,055,094	0	0	5,962,188	192.00
194.00	07950	26,392	15,566	0	0	0	194.00
194.02	07952	529,484	0	0	0	0	194.02
194.03	07953	36,014	298	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	3,212	765	0	0	0	194.05
194.06	07956	50,919	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS

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Period:  
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To 12/31/2016

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Cost Center Description			CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	MENTAL HEALTH OVERHEAD (CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
194.09	07959	NRCC	2,436	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	796,292	5,557,283	4,619,300	0	3,052,093	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.026000	0.415848	8,699.246704	0.000000	0.056922	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,428	391,165	196,541	0	177,722	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000634	0.029271	370.133710	0.000000	0.003315	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

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Cost Center Description		PARAMED PGRM-RADIOLOGY (ASSIGNED TIME)	PARAMED PGRM-LAB (ASSIGNED TIME)	
		23.00	23.01	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
4.01	00401			4.01
4.02	00402			4.02
4.03	00403			4.03
4.04	00404			4.04
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
17.01	01701			17.01
23.00	02300	100		23.00
23.01	02302		100	23.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	0	0	30.00
31.00	03100	0	0	31.00
40.00	04000	0	0	40.00
41.00	04100	0	0	41.00
43.00	04300	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	0	0	50.00
51.00	05100	0	0	51.00
51.01	05101	0	0	51.01
52.00	05200	0	0	52.00
54.00	05400	100	0	54.00
54.01	05401	0	0	54.01
54.08	05408	0	0	54.08
60.00	06000	0	100	60.00
63.00	06300	0	0	63.00
65.00	06500	0	0	65.00
66.00	06600	0	0	66.00
69.00	06900	0	0	69.00
70.00	07000	0	0	70.00
70.01	07001	0	0	70.01
71.00	07100	0	0	71.00
72.00	07200	0	0	72.00
73.00	07300	0	0	73.00
75.00	07500	0	0	75.00
76.00	03020	0	0	76.00
76.01	03950	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	0	0	90.00
91.00	09100	0	0	91.00
92.00	09200	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600	0	0	96.00
101.00	10100	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	0	0	113.00
116.00	11600	0	0	116.00
118.00		100	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	0	0	190.00
192.00	19200	0	0	192.00
194.00	07950	0	0	194.00
194.02	07952	0	0	194.02
194.03	07953	0	0	194.03
194.04	07954	0	0	194.04
194.05	07955	0	0	194.05
194.06	07956	0	0	194.06
194.07	07957	0	0	194.07
194.08	07958	0	0	194.08

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B-1  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description			PARAMED ED PGRM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PGRM-LAB (ASSIGNED TIME)	
			23.00	23.01	
194.09	07959	NRCC	0	0	194.09
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	255,425	23,976	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,554.250000	239.760000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,518	164	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	25.180000	1.640000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet C  
Part I  
Date/Time Prepared:  
5/26/2017 4:34 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	17,776,502		17,776,502	0	17,776,502	30.00
31.00	03100	INTENSIVE CARE UNIT	8,201,624		8,201,624	0	8,201,624	31.00
40.00	04000	SUBPROVIDER - IPF	2,329,581		2,329,581	0	2,329,581	40.00
41.00	04100	SUBPROVIDER - IRF	6,933,836		6,933,836	4,688	6,938,524	41.00
43.00	04300	NURSERY	619,289		619,289	0	619,289	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	7,957,588		7,957,588	0	7,957,588	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	2,587,806		2,587,806	0	2,587,806	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,761,989		1,761,989	0	1,761,989	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,949,471		10,949,471	0	10,949,471	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	1,977,982		1,977,982	0	1,977,982	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	481,851		481,851	0	481,851	54.08
60.00	06000	LABORATORY	6,785,572		6,785,572	0	6,785,572	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	844,578		844,578	0	844,578	63.00
65.00	06500	RESPIRATORY THERAPY	3,585,572	0	3,585,572	0	3,585,572	65.00
66.00	06600	PHYSICAL THERAPY	5,735,159	0	5,735,159	0	5,735,159	66.00
69.00	06900	ELECTROCARDIOLOGY	6,771,441		6,771,441	108,328	6,879,769	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,004,756		1,004,756	9,865	1,014,621	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,375,878		10,375,878	0	10,375,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,720,071		3,720,071	0	3,720,071	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,608,751		21,608,751	0	21,608,751	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,851,990		4,851,990	0	4,851,990	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	801,170		801,170	5,835	807,005	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	3,359,041		3,359,041	13,109	3,372,150	90.00
91.00	09100	EMERGENCY	11,035,322		11,035,322	33,634	11,068,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,192,741		4,192,741	0	4,192,741	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	194,476		194,476	0	194,476	96.00
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	1,587,899		1,587,899		1,587,899	116.00
200.00		Subtotal (see instructions)	148,031,936	0	148,031,936	175,459	148,207,395	200.00
201.00		Less Observation Beds	4,192,741		4,192,741		4,192,741	201.00
202.00		Total (see instructions)	143,839,195	0	143,839,195	175,459	144,014,654	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/26/2017 4:34 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	21,984,453		21,984,453	30.00
31.00	03100	INTENSIVE CARE UNIT	17,599,450		17,599,450	31.00
40.00	04000	SUBPROVIDER - IPF	4,625,587		4,625,587	40.00
41.00	04100	SUBPROVIDER - IRF	8,907,398		8,907,398	41.00
43.00	04300	NURSERY	1,504,994		1,504,994	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	12,922,865	17,202,799	30,125,664	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,349,309	9,986,902	11,336,211	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,682,790	426,868	6,109,658	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,640,363	73,873,590	85,513,953	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	2,286,690	15,276,305	17,562,995	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	226,475	226,475	54.08
60.00	06000	LABORATORY	15,085,173	39,661,097	54,746,270	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,645,193	1,443,855	3,089,048	63.00
65.00	06500	RESPIRATORY THERAPY	11,822,691	3,436,475	15,259,166	65.00
66.00	06600	PHYSICAL THERAPY	12,137,972	18,455,751	30,593,723	66.00
69.00	06900	ELECTROCARDIOLOGY	11,021,333	27,597,261	38,618,594	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	85,572	4,925,058	5,010,630	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,815,544	2,247,873	7,063,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,058,053	2,183,340	12,241,393	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,913,753	47,685,185	65,598,938	73.00
75.00	07500	ASC (NON-DISTINCT PART)	202,243	20,844,519	21,046,762	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	1,007,206	61,729	1,068,935	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	6,171,971	6,171,971	90.00
91.00	09100	EMERGENCY	8,630,917	44,182,051	52,812,968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,784,727	10,530,332	12,315,059	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	29,130	584,122	613,252	96.00
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	1,169,291	2,062,687	3,231,978	116.00
200.00		Subtotal (see instructions)	185,912,697	349,066,245	534,978,942	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	185,912,697	349,066,245	534,978,942	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.264146		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
51.01	05101 ENDOSCOPY	0.228278		51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.288394		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128043		54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0.112622		54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	2.127612		54.08
60.00	06000 LABORATORY	0.123946		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.273410		63.00
65.00	06500 RESPIRATORY THERAPY	0.234978		65.00
66.00	06600 PHYSICAL THERAPY	0.187462		66.00
69.00	06900 ELECTROCARDIOLOGY	0.178147		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 NEURODIAGNOSTICS	0.202494		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.303893		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.329407		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.230534		75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0.000000		76.00
76.01	03950 INPATIENT DIALYSIS	0.754962		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.546365		90.00
91.00	09100 EMERGENCY	0.209588		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340456		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.317122		96.00
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: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet C  
Part I  
Date/Time Prepared:  
5/26/2017 4:34 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	17,776,502	17,776,502	0	17,776,502	30.00
31.00	03100 INTENSIVE CARE UNIT	8,201,624	8,201,624	0	8,201,624	31.00
40.00	04000 SUBPROVIDER - IPF	2,329,581	2,329,581	0	2,329,581	40.00
41.00	04100 SUBPROVIDER - IRF	6,933,836	6,933,836	4,688	6,938,524	41.00
43.00	04300 NURSERY	619,289	619,289	0	619,289	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	7,957,588	7,957,588	0	7,957,588	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
51.01	05101 ENDOSCOPY	2,587,806	2,587,806	0	2,587,806	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,761,989	1,761,989	0	1,761,989	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,949,471	10,949,471	0	10,949,471	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	1,977,982	1,977,982	0	1,977,982	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	481,851	481,851	0	481,851	54.08
60.00	06000 LABORATORY	6,785,572	6,785,572	0	6,785,572	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	844,578	844,578	0	844,578	63.00
65.00	06500 RESPIRATORY THERAPY	3,585,572	3,585,572	0	3,585,572	65.00
66.00	06600 PHYSICAL THERAPY	5,735,159	5,735,159	0	5,735,159	66.00
69.00	06900 ELECTROCARDIOLOGY	6,771,441	6,771,441	108,328	6,879,769	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	1,004,756	1,004,756	9,865	1,014,621	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,375,878	10,375,878	0	10,375,878	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,720,071	3,720,071	0	3,720,071	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,608,751	21,608,751	0	21,608,751	73.00
75.00	07500 ASC (NON-DISTINCT PART)	4,851,990	4,851,990	0	4,851,990	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	801,170	801,170	5,835	807,005	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	3,359,041	3,359,041	13,109	3,372,150	90.00
91.00	09100 EMERGENCY	11,035,322	11,035,322	33,634	11,068,956	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,192,741	4,192,741	0	4,192,741	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	194,476	194,476	0	194,476	96.00
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	1,587,899	1,587,899		1,587,899	116.00
200.00	Subtotal (see instructions)	148,031,936	148,031,936	175,459	148,207,395	200.00
201.00	Less Observation Beds	4,192,741	4,192,741		4,192,741	201.00
202.00	Total (see instructions)	143,839,195	143,839,195	175,459	144,014,654	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/26/2017 4:34 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	21,984,453		21,984,453	30.00
31.00	03100	INTENSIVE CARE UNIT	17,599,450		17,599,450	31.00
40.00	04000	SUBPROVIDER - IPF	4,625,587		4,625,587	40.00
41.00	04100	SUBPROVIDER - IRF	8,907,398		8,907,398	41.00
43.00	04300	NURSERY	1,504,994		1,504,994	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	12,922,865	17,202,799	30,125,664	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,349,309	9,986,902	11,336,211	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,682,790	426,868	6,109,658	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,640,363	73,873,590	85,513,953	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	2,286,690	15,276,305	17,562,995	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	226,475	226,475	54.08
60.00	06000	LABORATORY	15,085,173	39,661,097	54,746,270	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,645,193	1,443,855	3,089,048	63.00
65.00	06500	RESPIRATORY THERAPY	11,822,691	3,436,475	15,259,166	65.00
66.00	06600	PHYSICAL THERAPY	12,137,972	18,455,751	30,593,723	66.00
69.00	06900	ELECTROCARDIOLOGY	11,021,333	27,597,261	38,618,594	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	85,572	4,925,058	5,010,630	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,815,544	2,247,873	7,063,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,058,053	2,183,340	12,241,393	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,913,753	47,685,185	65,598,938	73.00
75.00	07500	ASC (NON-DISTINCT PART)	202,243	20,844,519	21,046,762	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	1,007,206	61,729	1,068,935	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	6,171,971	6,171,971	90.00
91.00	09100	EMERGENCY	8,630,917	44,182,051	52,812,968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,784,727	10,530,332	12,315,059	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	29,130	584,122	613,252	96.00
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	1,169,291	2,062,687	3,231,978	116.00
200.00		Subtotal (see instructions)	185,912,697	349,066,245	534,978,942	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	185,912,697	349,066,245	534,978,942	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet C  
Part I  
Date/Time Prepared:  
5/26/2017 4:34 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
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
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
51.01	05101	ENDOSCOPY	0.000000		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.000000		54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0.000000		54.08
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	NEURODIAGNOSTICS	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000		76.00
76.01	03950	INPATIENT DIALYSIS	0.000000		76.01
<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>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
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: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 5/26/2017 4:34 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,810,640	0	2,810,640	18,579	151.28	30.00
31.00	INTENSIVE CARE UNIT	1,028,838		1,028,838	7,104	144.83	31.00
40.00	SUBPROVIDER - IPF	471,971	0	471,971	2,960	159.45	40.00
41.00	SUBPROVIDER - IRF	764,655	0	764,655	7,794	98.11	41.00
43.00	NURSERY	13,464		13,464	1,142	11.79	43.00
200.00	Total (Lines 30-199)	5,089,568		5,089,568	37,579		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,654	1,611,737				
31.00	INTENSIVE CARE UNIT	2,399	347,447				
40.00	SUBPROVIDER - IPF	1,026	163,596				
41.00	SUBPROVIDER - IRF	6,072	595,724				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	20,151	2,718,504				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/26/2017 4:34 pm
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Cost Center Description		Capital Related Cost (from Wkst. C, 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	731,926	30,125,664	0.024296	8,912,770	216,545	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101 ENDOSCOPY	423,038	11,336,211	0.037317	843,191	31,465	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	30,717	6,109,658	0.005028	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	873,664	85,513,953	0.010217	7,284,532	74,426	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	168,981	17,562,995	0.009621	1,311,792	12,621	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	151,605	226,475	0.669412	0	0	54.08
60.00	06000 LABORATORY	339,370	54,746,270	0.006199	10,413,186	64,551	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	4,372	3,089,048	0.001415	1,336,399	1,891	63.00
65.00	06500 RESPIRATORY THERAPY	216,462	15,259,166	0.014186	6,266,462	88,896	65.00
66.00	06600 PHYSICAL THERAPY	553,619	30,593,723	0.018096	3,720,457	67,325	66.00
69.00	06900 ELECTROCARDIOLOGY	626,591	38,618,594	0.016225	7,714,781	125,172	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	257,180	5,010,630	0.051327	51,300	2,633	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	53,464	7,063,417	0.007569	2,151,387	16,284	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	56,792	12,241,393	0.004639	4,400,679	20,415	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	450,094	65,598,938	0.006861	11,259,966	77,255	73.00
75.00	07500 ASC (NON-DISTINCT PART)	150,965	21,046,762	0.007173	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	278,044	1,068,935	0.260113	748,200	194,617	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	135,318	6,171,971	0.021925	0	0	90.00
91.00	09100 EMERGENCY	797,686	52,812,968	0.015104	3,671,623	55,456	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	662,914	12,315,059	0.053830	1,174,539	63,225	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	15,401	613,252	0.025114	0	0	96.00
200.00	Total (lines 50-199)	6,978,203	477,125,082		71,261,264	1,112,777	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/26/2017 4:34 pm	
Title XVIII			Hospital			PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,579	0.00	10,654	0		30.00
31.00	03100	INTENSIVE CARE UNIT	7,104	0.00	2,399	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,960	0.00	1,026	0		40.00
41.00	04100	SUBPROVIDER - IRF	7,794	0.00	6,072	0		41.00
43.00	04300	NURSERY	1,142	0.00	0	0		43.00
200.00		Total (lines 30-199)	37,579		20,151	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet D  
Part IV  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	255,425	0	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	0	0	0	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	0	0	0	54.08
60.00	06000	LABORATORY	0	0	23,976	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	279,401	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet D  
Part IV  
Date/Time Prepared:  
5/26/2017 4:34 pm

Cost Center Description		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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	30,125,664	0.000000	0.000000	8,912,770	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0	11,336,211	0.000000	0.000000	843,191	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,109,658	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,425	85,513,953	0.002987	0.002987	7,284,532	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0	17,562,995	0.000000	0.000000	1,311,792	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	0	226,475	0.000000	0.000000	0	54.08
60.00	06000	LABORATORY	23,976	54,746,270	0.000438	0.000438	10,413,186	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3,089,048	0.000000	0.000000	1,336,399	63.00
65.00	06500	RESPIRATORY THERAPY	0	15,259,166	0.000000	0.000000	6,266,462	65.00
66.00	06600	PHYSICAL THERAPY	0	30,593,723	0.000000	0.000000	3,720,457	66.00
69.00	06900	ELECTROCARDIOLOGY	0	38,618,594	0.000000	0.000000	7,714,781	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	5,010,630	0.000000	0.000000	51,300	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,063,417	0.000000	0.000000	2,151,387	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,241,393	0.000000	0.000000	4,400,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	65,598,938	0.000000	0.000000	11,259,966	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	21,046,762	0.000000	0.000000	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0.000000	0.000000	0	76.00
76.01	03950	INPATIENT DIALYSIS	0	1,068,935	0.000000	0.000000	748,200	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	6,171,971	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	52,812,968	0.000000	0.000000	3,671,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	12,315,059	0.000000	0.000000	1,174,539	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	613,252	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	279,401	477,125,082			71,261,264	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/26/2017 4:34 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	14,772,084	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
51.01	05101 ENDOSCOPY	0	4,923,686	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	21,759	26,759,506	79,931	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	4,968,679	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	54.08
60.00	06000 LABORATORY	4,561	6,605,901	2,893	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	822,503	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	2,509,304	0	65.00
66.00	06600 PHYSICAL THERAPY	0	269,572	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	9,294,667	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	1,864,964	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,926,472	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,883,340	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	20,097,808	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	46,697	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	8,761,930	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,573,828	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	26,320	109,080,941	82,824	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/26/2017 4:34 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	0.264146	14,772,084	0	441	3,901,987	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.228278	4,923,686	0	0	1,123,969	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.288394	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.128043	26,759,506	0	0	3,426,367	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.112622	4,968,679	0	0	559,583	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	2.127612	0	0	0	0	54.08
60.00	06000	LABORATORY	0.123946	6,605,901	595	0	818,775	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273410	822,503	0	0	224,881	63.00
65.00	06500	RESPIRATORY THERAPY	0.234978	2,509,304	0	0	589,631	65.00
66.00	06600	PHYSICAL THERAPY	0.187462	269,572	0	0	50,535	66.00
69.00	06900	ELECTROCARDIOLOGY	0.175341	9,294,667	0	0	1,629,736	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.200525	1,864,964	0	0	373,972	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960	1,926,472	20,771	0	2,829,910	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303893	1,883,340	0	0	572,334	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329407	20,097,808	458	155,519	6,620,359	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.230534	0	0	0	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.749503	46,697	0	0	35,000	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.544241	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.208951	8,761,930	0	0	1,830,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.340456	3,573,828	0	0	1,216,731	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.317122	0	0	0	0	96.00
200.00		Subtotal (see instructions)		109,080,941	21,824	155,960	25,804,584	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		109,080,941	21,824	155,960	25,804,584	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/26/2017 4:34 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	116		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
51.01 05101 ENDOSCOPY	0	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	0	0		54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	0	0		54.08
60.00 06000 LABORATORY	74	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	30,512	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	151	51,229		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03950 INPATIENT DIALYSIS	0	0		76.01
<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>				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	30,737	51,345		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	30,737	51,345		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0042 Component CCN: 15-S042		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part II Date/Time Prepared: 5/26/2017 4:34 pm	
Title XVIII				Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	731,926	30,125,664	0.024296	67	2 50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0 51.00
51.01	05101	ENDOSCOPY	423,038	11,336,211	0.037317	242	9 51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,717	6,109,658	0.005028	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	873,664	85,513,953	0.010217	84,736	866 54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	168,981	17,562,995	0.009621	0	0 54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	151,605	226,475	0.669412	0	0 54.08
60.00	06000	LABORATORY	339,370	54,746,270	0.006199	115,982	719 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,372	3,089,048	0.001415	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	216,462	15,259,166	0.014186	64,746	918 65.00
66.00	06600	PHYSICAL THERAPY	553,619	30,593,723	0.018096	22,062	399 66.00
69.00	06900	ELECTROCARDIOLOGY	626,591	38,618,594	0.016225	12,907	209 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
70.01	07001	NEURODIAGNOSTICS	257,180	5,010,630	0.051327	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,464	7,063,417	0.007569	3,398	26 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,792	12,241,393	0.004639	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	450,094	65,598,938	0.006861	194,410	1,334 73.00
75.00	07500	ASC (NON-DISTINCT PART)	150,965	21,046,762	0.007173	0	0 75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0 76.00
76.01	03950	INPATIENT DIALYSIS	278,044	1,068,935	0.260113	0	0 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	135,318	6,171,971	0.021925	0	0 90.00
91.00	09100	EMERGENCY	797,686	52,812,968	0.015104	129,268	1,952 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	12,315,059	0.000000	17,312	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,401	613,252	0.025114	0	0 96.00
200.00		Total (lines 50-199)	6,315,289	477,125,082		645,130	6,434 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/26/2017 4:34 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
<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
51.01 05101 ENDOSCOPY	0	0	0	0	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	255,425	0	255,425	54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	0	0	0	0	0	54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	0	0	54.08
60.00 06000 LABORATORY	0	0	23,976	0	23,976	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01 07001 NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01 03950 INPATIENT DIALYSIS	0	0	0	0	0	76.01
<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>						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00 Total (lines 50-199)	0	0	279,401	0	279,401	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/26/2017 4:34 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	30,125,664	0.000000	0.000000	67	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
51.01	05101 ENDOSCOPY	0	11,336,211	0.000000	0.000000	242	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	6,109,658	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	255,425	85,513,953	0.002987	0.002987	84,736	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	17,562,995	0.000000	0.000000	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	226,475	0.000000	0.000000	0	54.08
60.00	06000 LABORATORY	23,976	54,746,270	0.000438	0.000438	115,982	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	3,089,048	0.000000	0.000000	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	15,259,166	0.000000	0.000000	64,746	65.00
66.00	06600 PHYSICAL THERAPY	0	30,593,723	0.000000	0.000000	22,062	66.00
69.00	06900 ELECTROCARDIOLOGY	0	38,618,594	0.000000	0.000000	12,907	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	5,010,630	0.000000	0.000000	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,063,417	0.000000	0.000000	3,398	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	12,241,393	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	65,598,938	0.000000	0.000000	194,410	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	21,046,762	0.000000	0.000000	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0.000000	0.000000	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	1,068,935	0.000000	0.000000	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	6,171,971	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	52,812,968	0.000000	0.000000	129,268	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	12,315,059	0.000000	0.000000	17,312	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	613,252	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	279,401	477,125,082			645,130	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/26/2017 4:34 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	805	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
51.01	05101 ENDOSCOPY	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	253	0	0	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	0	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	54.08
60.00	06000 LABORATORY	51	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	0	0	76.01
<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>					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	304	805	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		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	0.264146	805	0	0	213	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.228278	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.288394	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.128043	0	0	0	0	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.112622	0	0	0	0	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	2.127612	0	0	0	0	54.08
60.00	06000	LABORATORY	0.123946	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273410	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.234978	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.187462	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.175341	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.200525	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303893	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329407	0	24	747	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.230534	0	0	0	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.749503	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.544241	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.208951	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.340456	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.317122	0	0	0	0	96.00
200.00		Subtotal (see instructions)		805	24	747	213	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)		805	24	747	213	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/26/2017 4:34 pm
	Title XVIII	Subprovider - IPF	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
51.01 05101 ENDOSCOPY	0	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	0	0		54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	0	0		54.08
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8	246		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03950 INPATIENT DIALYSIS	0	0		76.01
<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>				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	8	246		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	8	246		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part II Date/Time Prepared: 5/26/2017 4:34 pm		
Title XVIII				Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	731,926	30,125,664	0.024296	83,097	2,019	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	423,038	11,336,211	0.037317	44,220	1,650	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,717	6,109,658	0.005028	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	873,664	85,513,953	0.010217	387,904	3,963	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	168,981	17,562,995	0.009621	185,605	1,786	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	151,605	226,475	0.669412	0	0	54.08
60.00	06000	LABORATORY	339,370	54,746,270	0.006199	949,190	5,884	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,372	3,089,048	0.001415	16,844	24	63.00
65.00	06500	RESPIRATORY THERAPY	216,462	15,259,166	0.014186	1,077,489	15,285	65.00
66.00	06600	PHYSICAL THERAPY	553,619	30,593,723	0.018096	5,429,161	98,246	66.00
69.00	06900	ELECTROCARDIOLOGY	626,591	38,618,594	0.016225	129,602	2,103	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	257,180	5,010,630	0.051327	1,679	86	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,464	7,063,417	0.007569	190,828	1,444	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,792	12,241,393	0.004639	19,539	91	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	450,094	65,598,938	0.006861	1,039,719	7,134	73.00
75.00	07500	ASC (NON-DISTINCT PART)	150,965	21,046,762	0.007173	0	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03950	INPATIENT DIALYSIS	278,044	1,068,935	0.260113	11,540	3,002	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	135,318	6,171,971	0.021925	0	0	90.00
91.00	09100	EMERGENCY	797,686	52,812,968	0.015104	81,135	1,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	12,315,059	0.000000	234,128	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,401	613,252	0.025114	0	0	96.00
200.00		Total (lines 50-199)	6,315,289	477,125,082		9,881,680	143,942	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/26/2017 4:34 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
<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
51.01 05101 ENDOSCOPY	0	0	0	0	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	255,425	0	255,425	54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	0	0	0	0	0	54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	0	0	54.08
60.00 06000 LABORATORY	0	0	23,976	0	23,976	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01 07001 NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01 03950 INPATIENT DIALYSIS	0	0	0	0	0	76.01
<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>						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00 Total (lines 50-199)	0	0	279,401	0	279,401	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/26/2017 4:34 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	30,125,664	0.000000	0.000000	83,097	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
51.01	05101 ENDOSCOPY	0	11,336,211	0.000000	0.000000	44,220	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	6,109,658	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	255,425	85,513,953	0.002987	0.002987	387,904	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	17,562,995	0.000000	0.000000	185,605	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	226,475	0.000000	0.000000	0	54.08
60.00	06000 LABORATORY	23,976	54,746,270	0.000438	0.000438	949,190	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	3,089,048	0.000000	0.000000	16,844	63.00
65.00	06500 RESPIRATORY THERAPY	0	15,259,166	0.000000	0.000000	1,077,489	65.00
66.00	06600 PHYSICAL THERAPY	0	30,593,723	0.000000	0.000000	5,429,161	66.00
69.00	06900 ELECTROCARDIOLOGY	0	38,618,594	0.000000	0.000000	129,602	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	5,010,630	0.000000	0.000000	1,679	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,063,417	0.000000	0.000000	190,828	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	12,241,393	0.000000	0.000000	19,539	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	65,598,938	0.000000	0.000000	1,039,719	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	21,046,762	0.000000	0.000000	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0.000000	0.000000	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	1,068,935	0.000000	0.000000	11,540	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	6,171,971	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	52,812,968	0.000000	0.000000	81,135	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	12,315,059	0.000000	0.000000	234,128	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	613,252	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	279,401	477,125,082			9,881,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/26/2017 4:34 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	1,882	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
51.01	05101 ENDOSCOPY	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,159	18,960	57	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0	0	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	54.08
60.00	06000 LABORATORY	416	1,355	1	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	899	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	3,754	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	630	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,574	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	4,866	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,131	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	1,575	36,051	58	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/26/2017 4:34 pm
Title XVIII			Subprovider - IRF	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	0.264146	1,882	0	0	497	50.00	
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00	
51.01 05101 ENDOSCOPY	0.228278	0	0	0	0	51.01	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.288394	0	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.128043	18,960	0	0	2,428	54.00	
54.01 05401 RADIOLOGY-NON-CAMPUS	0.112622	0	0	0	0	54.01	
54.08 05408 RADIOLOGY-GSH BREAST CENTER	2.127612	0	0	0	0	54.08	
60.00 06000 LABORATORY	0.123946	1,355	0	0	168	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.273410	0	0	0	0	63.00	
65.00 06500 RESPIRATORY THERAPY	0.234978	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0.187462	899	0	0	169	66.00	
69.00 06900 ELECTROCARDIOLOGY	0.175341	3,754	0	0	658	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
70.01 07001 NEURODIAGNOSTICS	0.200525	0	0	0	0	70.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960	630	0	0	925	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.303893	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.329407	2,574	0	3,663	848	73.00	
75.00 07500 ASC (NON-DISTINCT PART)	0.230534	0	0	0	0	75.00	
76.00 03020 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00	
76.01 03950 INPATIENT DIALYSIS	0.749503	0	0	0	0	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0.544241	0	0	0	0	90.00	
91.00 09100 EMERGENCY	0.208951	4,866	0	0	1,017	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340456	1,131	0	0	385	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.317122	0	0	0	0	96.00	
200.00		Subtotal (see instructions)	36,051	0	3,663	7,095	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00		Net Charges (line 200 +/- line 201)	36,051	0	3,663	7,095	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/26/2017 4:34 pm
	Title XVIII	Subprovider - IRF	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
51.01 05101 ENDOSCOPY	0	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	0	0		54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	0	0		54.08
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,207		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03950 INPATIENT DIALYSIS	0	0		76.01
<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>				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	0	1,207		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	1,207		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/26/2017 4:34 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	0.264146	0	1,877,707	0	0
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0
51.01 05101 ENDOSCOPY	0.228278	0	1,090,083	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.288394	0	46,593	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.128043	0	8,063,393	0	0
54.01 05401 RADIOLOGY-NON-CAMPUS	0.112622	0	1,667,427	0	0
54.08 05408 RADIOLOGY-GSH BREAST CENTER	2.127612	0	24,720	0	0
60.00 06000 LABORATORY	0.123946	0	4,329,058	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.273410	0	157,599	0	0
65.00 06500 RESPIRATORY THERAPY	0.234978	0	375,095	0	0
66.00 06600 PHYSICAL THERAPY	0.187462	0	2,014,468	0	0
69.00 06900 ELECTROCARDIOLOGY	0.175341	0	3,012,275	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
70.01 07001 NEURODIAGNOSTICS	0.200525	0	537,576	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960	0	245,358	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.303893	0	238,314	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.329407	0	5,204,897	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0.230534	0	2,275,205	0	0
76.00 03020 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0
76.01 03950 INPATIENT DIALYSIS	0.749503	0	6,738	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0.544241	0	673,678	0	0
91.00 09100 EMERGENCY	0.208951	0	4,822,525	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340456	0	1,149,399	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.317122	0	63,758	0	0
200.00	Subtotal (see instructions)	0	37,875,866	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0
202.00	Net Charges (line 200 +/- line 201)	0	37,875,866	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/26/2017 4:34 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	495,989	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
51.01 05101 ENDOSCOPY	248,842	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	13,437	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,032,461	0		54.00
54.01 05401 RADIOLOGY-NON-CAMPUS	187,789	0		54.01
54.08 05408 RADIOLOGY-GSH BREAST CENTER	52,595	0		54.08
60.00 06000 LABORATORY	536,569	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	43,089	0		63.00
65.00 06500 RESPIRATORY THERAPY	88,139	0		65.00
66.00 06600 PHYSICAL THERAPY	377,636	0		66.00
69.00 06900 ELECTROCARDIOLOGY	528,175	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	107,797	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	360,421	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	72,422	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,714,530	0		73.00
75.00 07500 ASC (NON-DISTINCT PART)	524,512	0		75.00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03950 INPATIENT DIALYSIS	5,050	0		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	366,643	0		90.00
91.00 09100 EMERGENCY	1,007,671	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	391,320	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	20,219	0		96.00
200.00	Subtotal (see instructions)	8,175,306	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	8,175,306	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 4:34 pm
Cost Center Description		Title XVIII	Hospital	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)		18,579	1.00
2.00	Total inpatient days (including private room days, excluding swing-bed and newborn days)		18,579	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)		14,197	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)		10,654	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)		17,776,502	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)		17,776,502	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)		17,776,502	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)		956.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,193,854	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)		10,193,854	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 4:34 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	8,201,624	7,104	1,154.51	2,399	2,769,669	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)					18,778,980	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					31,742,503	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)					1,959,184	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,139,097	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,098,281	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					28,644,222	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)					4,382	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					956.81	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,192,741	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/26/2017 4:34 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	2,810,640	17,776,502	0.158110	4,192,741	662,914	90.00
91.00	Nursing School cost	0	17,776,502	0.000000	4,192,741	0	91.00
92.00	Allied health cost	0	17,776,502	0.000000	4,192,741	0	92.00
93.00	All other Medical Education	0	17,776,502	0.000000	4,192,741	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				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)		2,960	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,960	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,960	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)		1,026	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)		2,329,581	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,329,581	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)		2,329,581	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)		787.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		807,483	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)		807,483	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
				Component CCN: 15-S042		Date/Time Prepared: 5/26/2017 4:34 pm
				Title XVIII	Subprovider - I PF	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
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
<b>Cost Center Description</b>						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					148,967	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					956,450	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					163,596	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					6,738	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					170,334	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					786,116	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/26/2017 4:34 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	471,971	2,329,581	0.202599	0	0	90.00
91.00	Nursing School cost	0	2,329,581	0.000000	0	0	91.00
92.00	Allied health cost	0	2,329,581	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,329,581	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				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)		7,794	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,794	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		7,794	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)		6,072	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)		6,938,524	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)		6,938,524	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)		6,938,524	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)		890.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,405,537	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)		5,405,537	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
				Component CCN: 15-T042		Date/Time Prepared: 5/26/2017 4:34 pm
				Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
<b>Cost Center Description</b>						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,253,418	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,658,955	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					595,724	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					145,517	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					741,241	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					6,917,714	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/26/2017 4:34 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	764,655	6,938,524	0.110204	0	0	90.00
91.00	Nursing School cost	0	6,938,524	0.000000	0	0	91.00
92.00	Allied health cost	0	6,938,524	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,938,524	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/26/2017 4:34 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		17,045,808		30.00
31.00	03100 INTENSIVE CARE UNIT		5,485,380		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.264146	8,912,770	2,354,273	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101 ENDOSCOPY	0.228278	843,191	192,482	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.288394	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128043	7,284,532	932,733	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0.112622	1,311,792	147,737	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	2.127612	0	0	54.08
60.00	06000 LABORATORY	0.123946	10,413,186	1,290,673	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.273410	1,336,399	365,385	63.00
65.00	06500 RESPIRATORY THERAPY	0.234978	6,266,462	1,472,481	65.00
66.00	06600 PHYSICAL THERAPY	0.187462	3,720,457	697,444	66.00
69.00	06900 ELECTROCARDIOLOGY	0.178147	7,714,781	1,374,365	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.202494	51,300	10,388	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960	2,151,387	3,160,301	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.303893	4,400,679	1,337,336	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.329407	11,259,966	3,709,112	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.230534	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0.754962	748,200	564,863	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.546365	0	0	90.00
91.00	09100 EMERGENCY	0.209588	3,671,623	769,528	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340456	1,174,539	399,879	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.317122	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		71,261,264	18,778,980	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)		71,261,264		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/26/2017 4:34 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,612,450		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.264146	67	18	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101 ENDOSCOPY	0.228278	242	55	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.288394	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128043	84,736	10,850	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0.112622	0	0	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	2.127612	0	0	54.08
60.00	06000 LABORATORY	0.123946	115,982	14,376	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.273410	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.234978	64,746	15,214	65.00
66.00	06600 PHYSICAL THERAPY	0.187462	22,062	4,136	66.00
69.00	06900 ELECTROCARDIOLOGY	0.178147	12,907	2,299	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.202494	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960	3,398	4,992	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.303893	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.329407	194,410	64,040	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.230534	0	0	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0.754962	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.546365	0	0	90.00
91.00	09100 EMERGENCY	0.209588	129,268	27,093	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340456	17,312	5,894	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.317122	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		645,130	148,967	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)		645,130		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/26/2017 4:34 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		6,603,412	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.264146	83,097	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.228278	44,220	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.288394	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.128043	387,904	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.112622	185,605	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	2.127612	0	54.08
60.00	06000	LABORATORY	0.123946	949,190	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273410	16,844	63.00
65.00	06500	RESPIRATORY THERAPY	0.234978	1,077,489	65.00
66.00	06600	PHYSICAL THERAPY	0.187462	5,429,161	66.00
69.00	06900	ELECTROCARDIOLOGY	0.178147	129,602	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.202494	1,679	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960	190,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303893	19,539	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329407	1,039,719	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.230534	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.754962	11,540	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.546365	0	90.00
91.00	09100	EMERGENCY	0.209588	81,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.340456	234,128	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.317122	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		9,881,680	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)		9,881,680	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/26/2017 4:34 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,918,281		30.00
31.00	03100 INTENSIVE CARE UNIT		1,535,662		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		131,320		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.264146	1,127,601	297,851	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101 ENDOSCOPY	0.228278	117,736	26,877	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.288394	495,859	143,003	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128043	1,015,695	130,053	54.00
54.01	05401 RADIOLOGY-NON-CAMPUS	0.112622	199,528	22,471	54.01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	2.127612	0	0	54.08
60.00	06000 LABORATORY	0.123946	1,316,276	163,147	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.273410	143,553	39,249	63.00
65.00	06500 RESPIRATORY THERAPY	0.234978	1,031,604	242,404	65.00
66.00	06600 PHYSICAL THERAPY	0.187462	1,059,114	198,544	66.00
69.00	06900 ELECTROCARDIOLOGY	0.175341	961,680	168,622	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.200525	7,467	1,497	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960	420,186	617,236	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.303893	877,628	266,705	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.329407	1,563,087	514,892	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.230534	17,647	4,068	75.00
76.00	03020 MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03950 INPATIENT DIALYSIS	0.749503	87,885	65,870	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.544241	0	0	90.00
91.00	09100 EMERGENCY	0.208951	753,102	157,361	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340456	155,729	53,019	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.317122	2,542	806	96.00
200.00	Total (sum of lines 50-94 and 96-98)		11,353,919	3,113,675	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)		11,353,919		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/26/2017 4:34 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		331,915	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.264146	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.228278	120	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.288394	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.128043	9,202	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.112622	539	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	2.127612	0	54.08
60.00	06000	LABORATORY	0.123946	21,934	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273410	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.234978	6,137	65.00
66.00	06600	PHYSICAL THERAPY	0.187462	5,372	66.00
69.00	06900	ELECTROCARDIOLOGY	0.175341	1,620	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.200525	474	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960	1,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303893	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329407	24,741	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.230534	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.749503	435	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.544241	0	90.00
91.00	09100	EMERGENCY	0.208951	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.340456	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.317122	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		71,698	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)		71,698	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/26/2017 4:34 pm	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		346,938	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.264146	1,075	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.228278	2,784	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.288394	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.128043	21,998	54.00
54.01	05401	RADIOLOGY-NON-CAMPUS	0.112622	5,119	54.01
54.08	05408	RADIOLOGY-GSH BREAST CENTER	2.127612	0	54.08
60.00	06000	LABORATORY	0.123946	39,123	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.273410	904	63.00
65.00	06500	RESPIRATORY THERAPY	0.234978	12,303	65.00
66.00	06600	PHYSICAL THERAPY	0.187462	284,821	66.00
69.00	06900	ELECTROCARDIOLOGY	0.175341	5,169	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.200525	653	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.468960	10,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.303893	399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329407	41,195	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.230534	0	75.00
76.00	03020	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03950	INPATIENT DIALYSIS	0.749503	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.544241	0	90.00
91.00	09100	EMERGENCY	0.208951	4,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.340456	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.317122	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		430,289	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)		430,289	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/26/2017 4:34 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)		15,776,235	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		5,726,500	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)		908,662	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		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		180.03	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 Section 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 section 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 section 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 Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 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)		5.15	30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.63	31.00
32.00	Sum of lines 30 and 31		19.78	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.61	33.00
34.00	Disproportionate share adjustment (see instructions)		301,576	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/26/2017 4:34 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)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000104473	0.000103263	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	669,269	617,253	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	501,038	155,582	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	656,620		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)	23,369,593		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				<b>Amount</b>
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		23,369,593	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,823,244	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		53,264	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)		26,320	58.00
59.00	Total (sum of amounts on lines 49 through 58)		25,272,421	59.00
60.00	Primary payer payments		6,416	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		25,266,005	61.00
62.00	Deductibles billed to program beneficiaries		2,548,280	62.00
63.00	Coinurance billed to program beneficiaries		63,434	63.00
64.00	Allowable bad debts (see instructions)		190,074	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		123,548	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		84,629	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,777,839	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 DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		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)		86,488	70.93
70.94	HRR adjustment amount (see instructions)		-31,097	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/26/2017 4:34 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			65,821	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			22,767,409	71.00
71.01	Sequestration adjustment (see instructions)			455,348	71.01
72.00	Interim payments			22,310,469	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, 72, and 73)			1,592	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			197,528	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	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	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/26/2017 4:34 pm

		Title XVIII			Hospital		PPS	
	W/S E, Part A Line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	15,776,235	0	15,776,235		15,776,235	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,726,500	0		5,726,500	5,726,500	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	908,662	0	761,862	146,800	908,662	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	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	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<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	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0561	0.0561	0.0561	0.0561		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	301,576	0	221,262	80,314	301,576	11.00
11.01	Uncompensated care payments	36.00	656,620	0	501,038	155,582	656,620	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	0	12.00
13.00	Subtotal (see instructions)	47.00	23,369,593	0	17,260,397	6,109,196	23,369,593	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	23,369,593	0	17,260,397	6,109,196	23,369,593	15.00
16.00	Payment for inpatient program capital	50.00	1,823,244	0	1,343,420	479,824	1,823,244	16.00
17.00	Special add-on payments for new technologies	54.00	0	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	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/26/2017 4:34 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	18,603,817	6,589,020	25,192,837	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,710,922	0	1,252,193	458,729	1,710,922	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	112,322	0	91,227	21,095	112,322	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,823,244	0	1,343,420	479,824	1,823,244	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2017 4:34 pm	
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	15,776,235	15,776,235		15,776,235	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,726,500		5,726,500	5,726,500	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	908,662	761,862	146,800	908,662	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	0	0	0	0	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	0.0561	0.0561	0.0561		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	301,576	221,262	80,314	301,576	11.00
11.01	Uncompensated care payments	36.00	656,620	501,038	155,582	656,620	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	23,369,593	17,260,397	6,109,196	23,369,593	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	23,369,593	17,260,397	6,109,196	23,369,593	15.00
16.00	Payment for inpatient program capital	50.00	1,823,244	1,343,420	479,824	1,823,244	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>			18,603,817	6,589,020	25,192,837	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2017 4:34 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	1,710,922	1,252,193	458,729	1,710,922	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	112,322	91,227	21,095	112,322	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	1,823,244	1,343,420	479,824	1,823,244	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	86,488	79,655	6,833	86,488	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	-31,097	-17,353	-13,744	-31,097	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	65,821	65,821	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		82,082	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		25,721,760	2.00
3.00	PPS payments		20,204,051	3.00
4.00	Outlier payment (see instructions)		153,595	4.00
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 line 3 plus line 4 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		82,824	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		82,082	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		177,784	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)		177,784	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)		177,784	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		95,702	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		82,082	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, 8 and 9)		20,440,470	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		24	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,203,294	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)		16,319,234	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)		16,319,234	30.00
31.00	Primary payer payments		3,209	31.00
32.00	Subtotal (line 30 minus line 31)		16,316,025	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)		545,970	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		354,881	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		381,687	36.00
37.00	Subtotal (see instructions)		16,670,906	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-171	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	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)		16,671,077	40.00
40.01	Sequestration adjustment (see instructions)		333,422	40.01
41.00	Interim payments		16,341,650	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-3,995	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		254	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		213	2.00
3.00	PPS payments		358	3.00
4.00	Outlier payment (see instructions)		0	4.00
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 line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		254	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		771	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)		771	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)		771	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		517	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		254	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, 8 and 9)		358	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		5	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		607	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)		607	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		607	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		607	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	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)		607	40.00
40.01	Sequestration adjustment (see instructions)		12	40.01
41.00	Interim payments		487	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		108	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		1,207	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,037	2.00
3.00	PPS payments		5,116	3.00
4.00	Outlier payment (see instructions)		0	4.00
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 line 3 plus line 4 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		58	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,207	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		3,663	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)		3,663	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)		3,663	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,456	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		1,207	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, 8 and 9)		5,174	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)		890	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		5,491	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		5,491	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		5,491	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		5,491	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	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)		5,491	40.00
40.01	Sequestration adjustment (see instructions)		110	40.01
41.00	Interim payments		5,389	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-8	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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: 15-0042		Period: From 01/01/2016 To 12/31/2016		Worksheet E-1 Part I Date/Time Prepared: 5/26/2017 4:34 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		22,260,269		16,297,350	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	07/08/2016	50,200	07/08/2016	44,300	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		50,200		44,300	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		22,310,469		16,341,650	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		1,592		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		3,995	6.02	
7.00	Total Medicare program liability (see instructions)		22,312,061		16,337,655	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part I Date/Time Prepared: 5/26/2017 4:34 pm	
		Title XVIII	Subprovider - IPF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				487 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		729,431		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)		729,431		487 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		8,134		108 6.01
6.02	SETTLEMENT TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		737,565		595 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part I Date/Time Prepared: 5/26/2017 4:34 pm	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				
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		8,892,087		5,389
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		8,892,087		5,389
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		15,934		0
6.02	SETTLEMENT TO PROGRAM		0		8
7.00	Total Medicare program liability (see instructions)		8,908,021		5,381
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		5,459	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		13,053	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		852	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		21,301	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		534,978,942	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		10,182,162	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)		0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPSS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			888,202 1.00
2.00	Net IPF PPS Outlier Payments			2,010 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			8.087432 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			890,212 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			890,212 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			890,212 18.00
19.00	Deductibles			139,104 19.00
20.00	Subtotal (line 18 minus line 19)			751,108 20.00
21.00	Coinsurance			6,762 21.00
22.00	Subtotal (line 20 minus line 21)			744,346 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			12,257 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			7,967 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,542 25.00
26.00	Subtotal (sum of lines 22 and 24)			752,313 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			304 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			752,617 31.00
31.01	Sequestration adjustment (see instructions)			15,052 31.01
32.00	Interim payments			729,431 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			8,134 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			2,010 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part III Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			8,867,409 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0309 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			191,536 3.00
4.00	Outlier Payments			208,220 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			21.295082 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			9,267,165 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			9,267,165 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			9,267,165 19.00
20.00	Deductibles			167,216 20.00
21.00	Subtotal (line 19 minus line 20)			9,099,949 21.00
22.00	Coinurance			19,964 22.00
23.00	Subtotal (line 21 minus line 22)			9,079,985 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			12,703 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			8,257 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			9,238 26.00
27.00	Subtotal (sum of lines 23 and 25)			9,088,242 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			1,575 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			9,089,817 32.00
32.01	Sequestration adjustment (see instructions)			181,796 32.01
33.00	Interim payments			8,892,087 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			15,934 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			208,220 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet G  
Date/Time Prepared:  
5/26/2017 4:34 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	39,804,829	0	0	0	1.00
2.00	Temporary investments	30,155,173	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	61,699,489	0	0	0	4.00
5.00	Other receivable	8,776,923	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,682,052	0	0	0	6.00
7.00	Inventory	2,257,673	0	0	0	7.00
8.00	Prepaid expenses	4,505,852	0	0	0	8.00
9.00	Other current assets	18,570,364	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)	150,088,251	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	6,912,648	0	0	0	12.00
13.00	Land improvements	9,275,750	0	0	0	13.00
14.00	Accumulated depreciation	-5,371,023	0	0	0	14.00
15.00	Buildings	126,601,969	0	0	0	15.00
16.00	Accumulated depreciation	-60,443,914	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	201,679,450	0	0	0	23.00
24.00	Accumulated depreciation	-120,144,447	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	52,644,189	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)	211,154,622	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	1,257,809	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,257,809	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	362,500,682	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	26,206,923	0	0	0	37.00
38.00	Salaries, wages, and fees payable	16,838,704	0	0	0	38.00
39.00	Payroll taxes payable	1,050,817	0	0	0	39.00
40.00	Notes and loans payable (short term)	11,407,051	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	397,653	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	55,901,148	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	115,952,338	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	115,952,338	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	171,853,486	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	190,647,196				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)	190,647,196	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	362,500,682	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet G-1

Date/Time Prepared:  
5/26/2017 4:34 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		190,448,549		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		198,647				2.00
3.00	Total (sum of line 1 and line 2)		190,647,196		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)		190,647,196		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)		190,647,196		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/26/2017 4:34 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	23,526,544		23,526,544	1.00
2.00	SUBPROVIDER - IPF	5,127,903		5,127,903	2.00
3.00	SUBPROVIDER - IRF	8,916,726		8,916,726	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)	37,571,173		37,571,173	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	17,618,471		17,618,471	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)	17,618,471		17,618,471	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	55,189,644		55,189,644	17.00
18.00	Ancillary services	122,713,816	270,340,338	393,054,154	18.00
19.00	Outpatient services	12,991,715	79,105,913	92,097,628	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	1,169,291	2,062,687	3,231,978	26.00
27.00	ASC	202,243	24,274,198	24,476,441	27.00
27.01	PHYSICIAN OFFICE	13,671,146	47,317,550	60,988,696	27.01
27.02	MH RESIDENTIAL	0	292,408	292,408	27.02
27.03	MOB	0	319,289	319,289	27.03
27.04	IL HOSPICE	165,194	538,437	703,631	27.04
27.05	OTHER (SPECIFY)	0	0	0	27.05
27.06	OTHER (SPECIFY)	0	0	0	27.06
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	206,103,049	424,250,820	630,353,869	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		236,507,869		29.00
30.00	NURSING HOME EXPENSES	81,803,583			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)		81,803,583		36.00
37.00	MISC EXPENSES	1,009,789			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)		1,009,789		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		317,301,663		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0042

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet G-3

Date/Time Prepared:  
5/26/2017 4:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	630,353,869	1.00
2.00	Less contractual allowances and discounts on patients' accounts	425,298,957	2.00
3.00	Net patient revenues (line 1 minus line 2)	205,054,912	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	317,301,663	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-112,246,751	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	890,690	6.00
7.00	Income from investments	1,021,826	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	444,717	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	11,149,580	24.00
24.01	NURSING HOME REVENUE	98,938,585	24.01
25.00	Total other income (sum of lines 6-24)	112,445,398	25.00
26.00	Total (line 5 plus line 25)	198,647	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)	198,647	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042

Period: From 01/01/2016

Worksheet 0

Hospice CCN: 15-1526

To 12/31/2016

Date/Time Prepared: 5/26/2017 4:34 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	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		11,107	11,107	-11,107	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	175,963	175,963	-175,963	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	483,224	88,192	571,416	-278,476	292,940	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	1,177	1,177	0	1,177	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
<b>DIRECT PATIENT CARE SERVICE COST CENTERS</b>							
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	0	0	0	175,618	175,618	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	46,099	46,099	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	0	0	56,759	56,759	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	12,799	12,799	-5,236	7,563	42.00
43.00	OUTPATIENT SERVICES**	0	305,935	305,935	0	305,935	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
<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
100.00	TOTAL	483,224	595,173	1,078,397	-192,306	886,091	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		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet 0
		Hospice CCN: 15-1526		Date/Time Prepared: 5/26/2017 4:34 pm
		Hospice I		

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		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	292,940	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	1,177	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	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	175,618	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	46,099	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	56,759	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	7,563	42.00
43.00	OUTPATIENT SERVICES**	0	305,935	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	886,091	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: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2016 To 12/31/2016	Worksheet 0-2 Date/Time Prepared: 5/26/2017 4:34 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	0	0	163,132	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	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	0	0	42,822	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	0	0	52,724	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	11,889	11,889	-4,864	42.00
43.00	OUTPATIENT SERVICES	0	284,183	284,183	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	296,072	296,072	253,814	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		
26.00	PHYSICIAN SERVICES	0	0
27.00	NURSE PRACTITIONER	0	0
28.00	REGISTERED NURSE	0	163,132
29.00	LPN/LVN	0	0
30.00	PHYSICAL THERAPY	0	0
31.00	OCCUPATIONAL THERAPY	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0
33.00	MEDICAL SOCIAL SERVICES	0	42,822
34.00	SPIRITUAL COUNSELING	0	0
35.00	DIETARY COUNSELING	0	0
36.00	COUNSELING - OTHER	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	52,724
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0
39.00	PATIENT TRANSPORTATION	0	0
40.00	IMAGING SERVICES	0	0
41.00	LABS & DIAGNOSTICS	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	7,025
43.00	OUTPATIENT SERVICES	0	284,183
44.00	PALLIATIVE RADIATION THERAPY	0	0
45.00	PALLIATIVE CHEMOTHERAPY	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0
100.00	TOTAL *	0	549,886

\* 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: 15-0042  
 Hospice CCN: 15-1526

Period:  
 From 01/01/2016  
 To 12/31/2016

Worksheet 0-3  
 Date/Time Prepared:  
 5/26/2017 4:34 pm

		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	0	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	0	0	474	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	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	0	0	124	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	0	0	153	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN					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	35	35	-14	42.00
43.00	OUTPATIENT SERVICES	0	826	826	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	861	861	737	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	0
26.00	PHYSICIAN SERVICES	0	0
27.00	NURSE PRACTITIONER	0	0
28.00	REGISTERED NURSE	0	474
29.00	LPN/LVN	0	0
30.00	PHYSICAL THERAPY	0	0
31.00	OCCUPATIONAL THERAPY	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0
33.00	MEDICAL SOCIAL SERVICES	0	124
34.00	SPIRITUAL COUNSELING	0	0
35.00	DIETARY COUNSELING	0	0
36.00	COUNSELING - OTHER	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	153
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN		
39.00	PATIENT TRANSPORTATION	0	0
40.00	IMAGING SERVICES	0	0
41.00	LABS & DIAGNOSTICS	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	21
43.00	OUTPATIENT SERVICES	0	826
44.00	PALLIATIVE RADIATION THERAPY	0	0
45.00	PALLIATIVE CHEMOTHERAPY	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0
100.00	TOTAL *	0	1,598

\* 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: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2016 To 12/31/2016	Worksheet 0-4 Date/Time Prepared: 5/26/2017 4:34 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	0	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	0	0	12,012	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	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	0	0	3,153	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	0	0	3,882	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN					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	875	875	-358	42.00
43.00	OUTPATIENT SERVICES	0	20,926	20,926	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	21,801	21,801	18,689	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
26.00	PHYSICIAN SERVICES	0
27.00	NURSE PRACTITIONER	0
28.00	REGISTERED NURSE	12,012
29.00	LPN/LVN	0
30.00	PHYSICAL THERAPY	0
31.00	OCCUPATIONAL THERAPY	0
32.00	SPEECH/LANGUAGE PATHOLOGY	0
33.00	MEDICAL SOCIAL SERVICES	3,153
34.00	SPIRITUAL COUNSELING	0
35.00	DIETARY COUNSELING	0
36.00	COUNSELING - OTHER	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES	3,882
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	
39.00	PATIENT TRANSPORTATION	0
40.00	IMAGING SERVICES	0
41.00	LABS & DIAGNOSTICS	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE	517
43.00	OUTPATIENT SERVICES	20,926
44.00	PALLIATIVE RADIATION THERAPY	0
45.00	PALLIATIVE CHEMOTHERAPY	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0
100.00	TOTAL *	40,490

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

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

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

Period:  
 From 01/01/2016  
 To 12/31/2016

Worksheet 0-5  
 Date/Time Prepared:  
 5/26/2017 4:34 pm

Descriptions		Hospice I			
		HOSPICE DIRECT 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	95,903	95,903	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,437	6,437	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	191,394	191,394	3.00
4.00	ADMINISTRATIVE & GENERAL	292,940	162,774	455,714	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	87,312	87,312	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	25,938	25,938	7.00
8.00	DIETARY	1,177	0	1,177	8.00
9.00	NURSING ADMINISTRATION	0	131,439	131,439	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	530	530	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	81	81	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	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	549,886	0	549,886	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	1,598	0	1,598	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	40,490	0	40,490	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	0	0	0	99.00
100.00	TOTAL	886,091	701,808	1,587,899	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0042	Period: From 01/01/2016	Worksheet 0-6
		Hospice CCN: 15-1526	To 12/31/2016	Part I
				Date/Time Prepared: 5/26/2017 4:34 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	95,903	95,903			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,437		6,437		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	191,394	0	0	191,394	3.00
4.00	ADMINISTRATIVE & GENERAL	455,714	0	0	174,492	4.00
5.00	PLANT OPERATION & MAINTENANCE	87,312	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	6.00
7.00	HOUSEKEEPING	25,938	0	0	0	7.00
8.00	DIETARY	1,177	0	0	0	8.00
9.00	NURSING ADMINISTRATION	131,439	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	530	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	13.00
14.00	PHARMACY	81	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	17.00
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	50.00
51.00	HOSPICE ROUTINE HOME CARE	549,886			0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	1,598	3,614	243	641	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	40,490	92,289	6,194	16,261	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0			0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	1,587,899	95,903	6,437	191,394	1,587,899

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part I
		Hospice CCN: 15-1526		Date/Time Prepared: 5/26/2017 4:34 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	630,206				4.00
5.00	PLANT OPERATION & MAINTENANCE	57,455	144,767			5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0		6.00
7.00	HOUSEKEEPING	17,068	0		43,006	7.00
8.00	DIETARY	775	0		0	1,952
9.00	NURSING ADMINISTRATION	86,493	0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	349	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	53	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	361,851				51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	4,011	5,455	0	1,621	74
53.00	HOSPICE GENERAL INPATIENT CARE	102,151	139,312	0	41,385	1,878
<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
67.00	ADVERTISING	0	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0	68.00
69.00	THRIFT STORE	0	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	630,206	144,767	0	43,006	1,952

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part I
		Hospice CCN: 15-1526		Date/Time Prepared: 5/26/2017 4:34 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	217,932				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	879			10.00
11.00	MEDICAL RECORDS	0		0		11.00
12.00	STAFF TRANSPORTATION	0			0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	13.00
14.00	PHARMACY	0			0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	15.00
16.00	OTHER GENERAL SERVICE	0			0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	202,441	817	0	0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	586	2	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	14,905	60	0	0	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	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					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	217,932	879	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part I Date/Time Prepared: 5/26/2017 4:34 pm
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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	134					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	125	0	0		1,115,120	51.00
52.00	0	0	0	0	17,845	52.00
53.00	9	0	0	0	454,934	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	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	134	0	0	0	1,587,899	100.00

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

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

Period:  
From 01/01/2016  
To 12/31/2016

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Cost Center Descriptions		Hospice I				
		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	3,848				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		3,848			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	224,181		3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	204,383	-630,206	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	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	145	145	751	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,703	3,703	19,047	0	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	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)	95,903	6,437	191,394		100.00
101.00	UNIT COST MULTIPLIER	24.922817	1.672817	0.853748		101.00

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

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

Period:  
From 01/01/2016  
To 12/31/2016

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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	3,848					5.00
6.00	LAUNDRY & LINEN SERVICE	0	555				6.00
7.00	HOUSEKEEPING	0		3,848			7.00
8.00	DIETARY	0		0	555		8.00
9.00	NURSING ADMINISTRATION	0		0		7,808	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					7,253	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	145	21	145	21	21	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,703	534	3,703	534	534	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 I)	144,767	0	43,006	1,952	217,932	100.00
101.00	UNIT COST MULTIPLIER	37.621362	0.000000	11.176195	3.517117	27.911373	101.00

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

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

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet 0-6  
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Cost Center Descriptions		Hospice I					
		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	7,808					10.00
11.00	MEDICAL RECORDS		7,808				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	7,808	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	7,253	7,253	0	0	7,253	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	21	21	0	0	21	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	534	534	0	0	534	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)	879	0	0	0	134	100.00
101.00	UNIT COST MULTIPLIER	0.112577	0.000000	0.000000	0.000000	0.017162	101.00

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

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

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet 0-6  
Part II  
Date/Time Prepared:  
5/26/2017 4:34 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: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2016 To 12/31/2016	Worksheet 0-7 Date/Time Prepared: 5/26/2017 4:34 pm
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Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)				
			HCHC	HRHC	HIRC		
			2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.187462	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.329407	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.317122	0	0	0	5.00
6.00	LABORATORY	60.00	0.123946	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	1.468960	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	MH ANCILLARY OUTPATIENT	76.00	0.000000	0	0	0	10.00
10.01	INPATIENT DIALYSIS	76.01	0.749503	0	0	0	10.01
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						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	MH ANCILLARY OUTPATIENT	0	0	0	0	0	10.00
10.01	INPATIENT DIALYSIS	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0042

Period: From 01/01/2016

Worksheet 0-8

Hospice CCN: 15-1526

To 12/31/2016

Date/Time Prepared: 5/26/2017 4:34 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)			1,115,120	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			7,253	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			153.75	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,841	0		9.00
10.00	Program cost (line 8 times line 9)	590,554	0		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)			17,845	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			21	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			849.76	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
<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)			454,934	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			534	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			851.94	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	344	0		19.00
20.00	Program cost (line 18 times line 19)	293,067	0		20.00
<b>TOTAL HOSPICE CARE</b>					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,587,899	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			7,808	22.00
23.00	Average cost per diem (line 21 divided by line 22)			203.37	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0042	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/26/2017 4:34 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,710,922	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		112,322	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		58.52	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)		1,823,244	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