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: 15-0037	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/16/2017 10:23 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/16/2017 Time: 10:23 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 HANCOCK REGIONAL HOSPITAL (15-0037) 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	60,810	52,803	0	6,860	1.00
2.00	Subprovider - IPF	0	498	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		6,906		0	10.00
200.00	Total	0	61,308	59,709	0	6,860	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/16/2017 10:17 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: .10 NORTH STATE STREET	PO Box:			1.00
2.00	City: GREENFIELD	State: IN	Zip Code: 46140-	County: HANCOCK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HANCOCK REGIONAL HOSPITAL	150037	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	HANCOCK REGIONAL GERO PSYCH UNIT	15S037	26900	4	12/01/1996	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HANCOCK REGIONAL HOSPICE	151547	26900		02/02/1996				14.00
15.00	Hospital-Based Health Clinic - RHC	KNIGHTSTOWN RURAL HEALTH	153987	26900		09/22/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	39	889	0	0	400	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/16/2017 10:17 am

		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	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/16/2017 10:17 am

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

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

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

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

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		1.00	2.00	3.00	
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	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
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. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	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	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	488,206	0	0	118.01

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

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/16/2017 10:17 am

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	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. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/16/2017 10:17 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/06/2017	Y	04/06/2017	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: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/16/2017 10:17 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0037	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/16/2017 10:17 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/16/2017 10:17 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	37	13,542	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)		37	13,542	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,784	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						13.00
14.00	Total (see instructions)		61	22,326	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,660		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		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	7	2,562			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		78				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: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/16/2017 10:17 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,059	23	3,679			1.00
2.00	HMO and other (see instructions)	737	1,281				2.00
3.00	HMO IPF Subprovider	5	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,059	23	3,679			7.00
8.00	INTENSIVE CARE UNIT	2,587	8	5,460			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)	3,646	31	9,139	0.00	837.35	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,739	0	3,030	0.00	19.65	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	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	894	0.00	18.44	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	94	0	2,159	0.00	0.78	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	876.22	27.00
28.00	Observation Bed Days		0	103			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			37			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	16	32			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: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/16/2017 10:17 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,179	229	2,714	1.00
2.00	HMO and other (see instructions)			209	97		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,179	229	2,714	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	209	0	231	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/16/2017 10:17 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	40,773,804	0	40,773,804	1,267,453.00	32.17	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		103,458	0	103,458	4,006.00	25.83	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,801,218	122,425	5,923,643	187,733.00	31.55	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		226,845	0	226,845	3,784.00	59.95	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		254,473	0	254,473	2,215.00	114.89	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,845,975	0	8,845,975			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,673,422	0	1,673,422			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		26,981	0	26,981			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/16/2017 10:17 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	425,773	0	425,773	9,873.00	43.12	26.00
27.00	Administrative & General	5.00	7,180,125	-122,425	7,057,700	198,489.00	35.56	27.00
28.00	Administrative & General under contract (see inst.)		774,034	0	774,034	4,003.00	193.36	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	973,239	0	973,239	32,856.00	29.62	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,002,116	0	1,002,116	63,052.00	15.89	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,250,874	-812,023	438,851	24,455.00	17.95	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	812,023	812,023	46,334.00	17.53	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,066,629	0	1,066,629	22,930.00	46.52	38.00
39.00	Central Services and Supply	14.00	70,078	0	70,078	4,244.00	16.51	39.00
40.00	Pharmacy	15.00	1,497,045	-16,592	1,480,453	36,184.00	40.91	40.00
41.00	Medical Records & Medical Records Library	16.00	651,124	0	651,124	25,770.00	25.27	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/16/2017 10:17 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		41,444,380	0	41,444,380	1,267,450.00	32.70	1.00
2.00	Excluded area salaries (see instructions)		5,801,218	122,425	5,923,643	187,733.00	31.55	2.00
3.00	Subtotal salaries (line 1 minus line 2)		35,643,162	-122,425	35,520,737	1,079,717.00	32.90	3.00
4.00	Subtotal other wages & related costs (see inst.)		481,318	0	481,318	5,999.00	80.23	4.00
5.00	Subtotal wage-related costs (see inst.)		8,845,975	0	8,845,975	0.00	24.90	5.00
6.00	Total (sum of lines 3 thru 5)		44,970,455	-122,425	44,848,030	1,085,716.00	41.31	6.00
7.00	Total overhead cost (see instructions)		14,891,037	-139,017	14,752,020	468,190.00	31.51	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/16/2017 10:17 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,371,433	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	5,918	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	5,699,220	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	239,315	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	135,827	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)	85,623	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	126,557	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,777,151	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	16,339	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	14,440	22.00
23.00	Tuition Reimbursement	74,555	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,546,378	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	226,845	10,546,378	1.00
2.00	Hospital	226,845	10,546,378	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	0	0	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 RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-8 | Date/Time Prepared: 5/16/2017 10:17 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			224 WEST MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	KNIGHTSTOWN		IN	46148	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		137632		07/01/2015	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0037
Component CCN: 15-3987

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

Worksheet S-8
Date/Time Prepared:
5/16/2017 10:17 am

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA | Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	6,075	71	520	6,666	11.00
12.00	Hospice Inpatient Respite Care	307	0	0	307	12.00
13.00	Hospice General Inpatient Care	398	0	17	415	13.00
14.00	Total Hospice Days	6,780	71	537	7,388	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/16/2017 10:17 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.276155	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,606,654	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	11,262,104	6.00
7.00	Medicaid cost (line 1 times line 6)	3,110,086	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	4,383,686	0	4,383,686	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	1,210,577	0	1,210,577	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,210,577	0	1,210,577	23.00

		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?		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)	11,862,832	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	162,133	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	11,700,699	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,231,207	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,441,784	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,441,784	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		9,800,388	9,800,388	0	9,800,388	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	425,773	8,104,928	8,530,701	0	8,530,701	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,180,125	10,666,526	17,846,651	-699,142	17,147,509	5.00
7.00	00700	OPERATION OF PLANT	973,239	4,808,670	5,781,909	3,408	5,785,317	7.00
9.00	00900	HOUSEKEEPING	1,002,116	764,378	1,766,494	0	1,766,494	9.00
10.00	01000	DIETARY	1,250,874	979,877	2,230,751	-1,448,265	782,486	10.00
11.00	01100	CAFETERIA	0	0	0	1,448,265	1,448,265	11.00
13.00	01300	NURSING ADMINISTRATION	1,066,629	212,685	1,279,314	0	1,279,314	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70,078	52,681	122,759	0	122,759	14.00
15.00	01500	PHARMACY	1,497,045	8,366,389	9,863,434	-20,946	9,842,488	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	651,124	258,637	909,761	11,074	920,835	16.00
23.00	02300	PARAMED ED PRGM	103,569	17,613	121,182	0	121,182	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,689,780	660,905	3,350,685	0	3,350,685	30.00
31.00	03100	INTENSIVE CARE UNIT	3,437,613	642,725	4,080,338	0	4,080,338	31.00
40.00	04000	SUBPROVIDER - IPF	1,235,734	237,833	1,473,567	0	1,473,567	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,461,936	2,455,868	4,917,804	0	4,917,804	50.00
51.00	05100	RECOVERY ROOM	227,006	33,231	260,237	0	260,237	51.00
53.00	05300	ANESTHESIOLOGY	0	145,024	145,024	0	145,024	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,787,831	1,704,756	4,492,587	0	4,492,587	54.00
60.00	06000	LABORATORY	1,637,935	2,456,296	4,094,231	5,414	4,099,645	60.00
65.00	06500	RESPIRATORY THERAPY	1,182,377	214,428	1,396,805	7,236	1,404,041	65.00
66.00	06600	PHYSICAL THERAPY	1,054,640	117,038	1,171,678	0	1,171,678	66.00
67.00	06700	OCCUPATIONAL THERAPY	306,053	25,413	331,466	0	331,466	67.00
68.00	06800	SPEECH PATHOLOGY	166,284	18,353	184,637	0	184,637	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	547,618	222,235	769,853	26,424	796,277	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,236,634	3,236,634	0	3,236,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,608,747	2,608,747	0	2,608,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	53,263	5,253	58,516	0	58,516	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	103,458	245,852	349,310	0	349,310	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	667,135	205,477	872,612	0	872,612	90.01
90.02	09002	DIABETES CLINIC	41,856	6,146	48,002	0	48,002	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	43,437	29,697	73,134	0	73,134	90.04
90.05	09005	PRIME TIME	0	100,341	100,341	0	100,341	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	272,752	156,555	429,307	0	429,307	90.06
90.07	04951	ONCOLOGY	574,681	910,590	1,485,271	0	1,485,271	90.07
90.08	04950	ANDERSON WOMENS CENTER	258,334	40,722	299,056	0	299,056	90.08
91.00	09100	EMERGENCY	2,341,594	570,487	2,912,081	0	2,912,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,178,493	895,125	2,073,618	0	2,073,618	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,490,382	61,978,503	99,468,885	-666,532	98,802,353	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	548,863	548,863	-32,610	516,253	190.01
190.02	19002	PHYSICIAN BUILDING	0	62,641	62,641	0	62,641	190.02
190.03	19003	PRIVATE DUTY	191,424	219,815	411,239	0	411,239	190.03
190.04	19004	MARKETING	0	0	0	699,142	699,142	190.04
190.05	19005	SPORTS PHYSICALS	52,141	4,728	56,869	0	56,869	190.05
190.06	19006	FOUNDATION	219,804	37,011	256,815	0	256,815	190.06
190.07	19007	ASC	0	2,812	2,812	0	2,812	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	1,362,229	2,047,822	3,410,051	0	3,410,051	190.09
190.10	19010	HANCOCK WELLNESS	805,568	477,587	1,283,155	0	1,283,155	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	166	16,456	16,622	0	16,622	190.12
190.13	19013	MCCORD WELLNESS	465,325	370,564	835,889	0	835,889	190.13
190.14	19014	3 WEST UNIT	186,765	179,228	365,993	0	365,993	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	79,500	79,500	0	79,500	190.15
190.16	19016	THORACI	0	38,570	38,570	0	38,570	190.16
200.00		TOTAL (SUM OF LINES 118-199)	40,773,804	66,064,100	106,837,904	0	106,837,904	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-548,312	9,252,076		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,392,631	6,138,070		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,996,937	13,150,572		5.00
7.00	00700	OPERATION OF PLANT	-20,533	5,764,784		7.00
9.00	00900	HOUSEKEEPING	-67,600	1,698,894		9.00
10.00	01000	DIETARY	-458,855	323,631		10.00
11.00	01100	CAFETERIA	-52,526	1,395,739		11.00
13.00	01300	NURSING ADMINISTRATION	-14,811	1,264,503		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-35,915	86,844		14.00
15.00	01500	PHARMACY	-829,597	9,012,891		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-71,987	848,848		16.00
23.00	02300	PARAMED ED PRGM	-45,060	76,122		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-173,493	3,177,192		30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,080,338		31.00
40.00	04000	SUBPROVIDER - IPF	-96,000	1,377,567		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-527,508	4,390,296		50.00
51.00	05100	RECOVERY ROOM	0	260,237		51.00
53.00	05300	ANESTHESIOLOGY	-136,598	8,426		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-19,381	4,473,206		54.00
60.00	06000	LABORATORY	-179,288	3,920,357		60.00
65.00	06500	RESPIRATORY THERAPY	-182,992	1,221,049		65.00
66.00	06600	PHYSICAL THERAPY	0	1,171,678		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	331,466		67.00
68.00	06800	SPEECH PATHOLOGY	0	184,637		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	-428	795,849		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,236,634		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,608,747		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	58,516		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-11,464	337,846		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	872,612		90.01
90.02	09002	DIABETES CLINIC	0	48,002		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	-4,125	69,009		90.04
90.05	09005	PRIME TIME	0	100,341		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	-6,707	422,600		90.06
90.07	04951	ONCOLOGY	-571,713	913,558		90.07
90.08	04950	ANDERSON WOMENS CENTER	-7,215	291,841		90.08
91.00	09100	EMERGENCY	-60,369	2,851,712		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	-86,502	1,987,116		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-10,598,547	88,203,806		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	516,253		190.01
190.02	19002	PHYSICIAN BUILDING	0	62,641		190.02
190.03	19003	PRIVATE DUTY	0	411,239		190.03
190.04	19004	MARKETING	0	699,142		190.04
190.05	19005	SPORTS PHYSICALS	0	56,869		190.05
190.06	19006	FOUNDATION	0	256,815		190.06
190.07	19007	ASC	0	2,812		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.08
190.09	19009	HANCOCK OB	0	3,410,051		190.09
190.10	19010	HANCOCK WELLNESS	0	1,283,155		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	16,622		190.12
190.13	19013	MCCORD WELLNESS	0	835,889		190.13
190.14	19014	3 WEST UNIT	0	365,993		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	79,500		190.15
190.16	19016	THORACI	0	38,570		190.16
200.00		TOTAL (SUM OF LINES 118-199)	-10,598,547	96,239,357		200.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/16/2017 10:17 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	812,023	636,242		1.00
	TOTALS		812,023	636,242		
	B - PLANT RECLASS					
1.00	OPERATION OF PLANT	7.00	0	3,408		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	11,074		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	10,892		3.00
4.00	RESPIRATORY THERAPY	65.00	0	7,236		4.00
	TOTALS		0	32,610		
	C - MARKETING RECLASS					
1.00	MARKETING	190.04	122,425	576,717		1.00
	TOTALS		122,425	576,717		
	D - OUTPATIENT PROCEDURE					
1.00	LABORATORY	60.00	4,300	1,114		1.00
2.00	ELECTROCARDIOLOGY	69.00	12,292	3,240		2.00
	TOTALS		16,592	4,354		
500.00	Grand Total: Increases		951,040	1,249,923		500.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/16/2017 10:17 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	812,023	636,242	0		1.00
	TOTALS		812,023	636,242			
	B - PLANT RECLASS						
1.00	PROFESSIONAL BUILDING	190.01	0	32,610	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
	TOTALS		0	32,610			
	C - MARKETING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	122,425	576,717	0		1.00
	TOTALS		122,425	576,717			
	D - OUTPATIENT PROCEDURE						
1.00	PHARMACY	15.00	16,592	4,354	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		16,592	4,354			
500.00	Grand Total: Decreases		951,040	1,249,923			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/16/2017 10:17 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,241,194	0	0	0	0	1.00
2.00	Land Improvements	6,578,254	1,072,303	0	1,072,303	0	2.00
3.00	Buildings and Fixtures	45,256,069	2,195,256	0	2,195,256	126,052	3.00
4.00	Building Improvements	59,255,788	3,005,518	0	3,005,518	26,900	4.00
5.00	Fixed Equipment	6,023,237	11,722,139	0	11,722,139	8,800,849	5.00
6.00	Movable Equipment	71,534,950	9,426,740	0	9,426,740	125,199	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	189,889,492	27,421,956	0	27,421,956	9,079,000	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	189,889,492	27,421,956	0	27,421,956	9,079,000	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,241,194	0	1.00
2.00	Land Improvements	7,650,557	0	2.00
3.00	Buildings and Fixtures	47,325,273	0	3.00
4.00	Building Improvements	62,234,406	0	4.00
5.00	Fixed Equipment	8,944,527	0	5.00
6.00	Movable Equipment	80,836,491	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	208,232,448	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	208,232,448	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	9,800,388	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	9,800,388	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	NEW CAP REL COSTS-BLDG & FIXT	0	9,800,388		1.00
3.00	Total (sum of lines 1-2)	0	9,800,388		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III | Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	47,325,273	0	47,325,273	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	47,325,273	0	47,325,273	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	9,800,388	-546,461	1.00
3.00	Total (sum of lines 1-2)	0	0	0	9,800,388	-546,461	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-1,851	0	0	0	9,252,076	1.00
3.00	Total (sum of lines 1-2)	-1,851	0	0	0	9,252,076	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,847,675			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing 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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HRH MMO RENTAL INCOME	B	-1,851	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.00
33.02	HRH OTHER REVENUE SALES TAX	B	44,633	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	HRH OTHER REVENUE MISCELLANEOUS REVE	B	-27,202	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.05	HRH OTHER REVENUE CHARGE CARD-OTHER	B	-1,431	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.07	HRH MED STAFF SERV QA APPLICATION FE	B	-13,300	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	HRH MEDICAL DUES MEDICAL STAFF DUES	B	-19,050	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HRH PAT FIN. SERV. BUSINESS SERV-COP	B	-2,040	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.11	HRH INFO SERVICES MISCELLANEOUS REVE	B	-464,580	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HRH ACCOUNTING MISCELLANEOUS REVENUE	B	-2,259	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HRH ACCOUNTING MANAGEMENT FEES	B	-9,116	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	HRH EXEC ADMIN MISCELLANEOUS REVENUE	B	-36,000	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.17	HRH PURCHASING MISCELLANEOUS REVENUE	B	-29	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	HRH COMMUNICATIONS MISCELLANEOUS REV	B	-3,188	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HRH COMMUNICATIONS PHONE LEASE REVEN	B	-184,349	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	HRH COMM EDUCATION MISCELLANEOUS REV	B	-280	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	HRH COMM EDUCATION EDUCATION SERVICE	B	-8,150	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	HRH COMM EDUCATION CAR SEAT STATE FU	B	-3,845	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23			0		0.00	0	33.23
33.26	HRH GAIN/LOSS INVENTORY	B	-22,933	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	HRH GAIN/LOSS GROSS VARIANCE INVENTO	B	10,264	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	HRH SECURITY MISCELLANEOUS REVENUE	B	-1,200	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	HRH HPN IT DEPT MISC REVENUE	B	-177,221	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.31	HRH PLANT OFFSITE SERVICES	B	-20,083	OPERATION OF PLANT	7.00	0	33.31
33.34	HRH HOUSEKEEPING ENVIRONMENTAL SERVI	B	-67,600	HOUSEKEEPING	9.00	0	33.34
33.35	HRH NUTRITIONAL SER REBATES/REFUNDS	B	-4,637	DIETARY	10.00	0	33.35
33.36	HRH NUTRITIONAL SER LTACH REVENUE	B	-57,188	DIETARY	10.00	0	33.36
33.38	HRH CLINICAL EDUCAT AHA COURSE REVEN	B	-14,811	NURSING ADMINISTRATION	13.00	0	33.38
33.40	HRH OTHER REVENUE REBATES/REFUNDS	B	-30,924	CENTRAL SERVICES & SUPPLY	14.00	0	33.40
33.41	HRH OTHER REVENUE DISCOUNTS EARNED O	B	-4,991	CENTRAL SERVICES & SUPPLY	14.00	0	33.41
33.42	HRH PHARMACY MISCELLANEOUS REVENUE	B	-3,209	PHARMACY	15.00	0	33.42
33.43	HRH PHARMACY REBATES/REFUNDS	B	-30,689	PHARMACY	15.00	0	33.43
33.44	HRH ASSOCIATE PHARM RETAIL PHARMACY-	B	-658,166	PHARMACY	15.00	0	33.44
33.45	HRH ASSOCIATE PHARM HOSPICE PHARMACY	B	-108,064	PHARMACY	15.00	0	33.45
33.46	HRH ASSOCIATE PHARM MISCELLANEOUS RE	B	-29,469	PHARMACY	15.00	0	33.46

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/16/2017 10:17 am

	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	
33.47	HRH HEALTH INFO SER MEDICAL RECORDS-	B	-3,421	MEDICAL RECORDS & LIBRARY	16.00	0	33.47
33.48	HRH HEALTH INFO SER MISCELLANEOUS RE	B	-68,566	MEDICAL RECORDS & LIBRARY	16.00	0	33.48
33.49	XRAY SCHOOL TUITION REVENUE	B	-45,060	PARAMED ED PRGM	23.00	0	33.49
33.50	HRH ANDIS UNIT REBATES/REFUNDS	B	-718	ADULTS & PEDIATRICS	30.00	0	33.50
33.55	HRH DIAG IMAGING HEARTBEATS REVENUE	B	-7,144	RADIOLOGY-DIAGNOSTIC	54.00	0	33.55
33.56	HRH PIC-CT MISCELLANEOUS EXPENSE	B	26	RADIOLOGY-DIAGNOSTIC	54.00	0	33.56
33.58	HRH MMO-RAD HEARTBEATS REVENUE	B	-770	RADIOLOGY-DIAGNOSTIC	54.00	0	33.58
33.61	HRH LAB WATER TESTING	B	-75,150	LABORATORY	60.00	0	33.61
33.62	HRH LAB HEARTBEATS REVENUE	B	-41,601	LABORATORY	60.00	0	33.62
33.64	HRH SLEEP STUDY CLINIC MANAGMENT	B	-57,216	RESPIRATORY THERAPY	65.00	0	33.64
33.65	HRH SLEEP STUDY SLEEP STUDY FEES	B	-109,276	RESPIRATORY THERAPY	65.00	0	33.65
33.67	HRH CARDIO SERV HEARTBEATS REVENUE	B	-428	ELECTROCARDIOLOGY	69.00	0	33.67
33.68	HRH KNIGHTSTOWN OFF KNIGHTSTOWN OFF-	B	-52	RURAL HEALTH CLINIC	88.00	0	33.68
33.72	HRH MCCORDS WOUND PHYS OTHER REVENUE	B	-6,707	SHELBYVILLE WOUND CLINIC	90.06	0	33.72
33.74	HRH MED ONCOLOGY MISCELLANEOUS REVEN	B	-80,551	ONCOLOGY	90.07	0	33.74
33.77	HRH E R REBATES/REFUNDS	B	-369	EMERGENCY	91.00	0	33.77
33.81	HRH HOSPICE MISCELLANEOUS REVENUE	B	-86,502	HOSPICE	116.00	0	33.81
33.82	MOW	A	-397,030	DIETARY	10.00	0	33.82
33.83	CAFETERIA GUEST MEALS	A	-52,526	CAFETERIA	11.00	0	33.83
33.84	PHYSICIAN RECRUITMENT FEES	A	-82,824	ADMINISTRATIVE & GENERAL	5.00	0	33.84
33.85	DONATIONS & SPONSORSHIPS	A	-129,041	ADMINISTRATIVE & GENERAL	5.00	0	33.85
33.86	ADVERTISING FEE	A	-2,433	ADMINISTRATIVE & GENERAL	5.00	0	33.86
33.87	ADVERTISING FEE	A	-287,824	ADMINISTRATIVE & GENERAL	5.00	0	33.87
33.88	ADVERTISING FEE	A	-253	RURAL HEALTH CLINIC	88.00	0	33.88
33.92	ADVERTISING FEE	A	-7,215	ANDERSON WOMENS CENTER	90.08	0	33.92
33.93	SELF INSURANCE CLAIM EXPENSE	A	-2,392,631	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.93
33.94	IHA LOBBYING EXPENSE	A	-1,969	ADMINISTRATIVE & GENERAL	5.00	0	33.94
33.95	AHA LOBBYING EXPENSE	A	-5,719	ADMINISTRATIVE & GENERAL	5.00	0	33.95
33.96	PHY OFFICE BLDG	A	-266,029	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.96
33.99	PHY OFFICE BLDG	A	-11,493	RADIOLOGY-DIAGNOSTIC	54.00	0	33.99
34.00	PHY OFFICE BLDG	A	-5,669	RURAL HEALTH CLINIC	88.00	0	34.00
34.01	INTEREST REVENUE	B	-1,851	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	34.01
34.02	RENTAL PROPERTIES EXPENSE	A	-89,355	ADMINISTRATIVE & GENERAL	5.00	0	34.02
34.03	RENTAL PROPERTIES EXPENSE	A	-278,581	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	34.03
34.04	RENTAL PROPERTIES EXPENSE	A	-450	OPERATION OF PLANT	7.00	0	34.04
34.05	TELEPHONE SERVICES	A	-37,043	ADMINISTRATIVE & GENERAL	5.00	0	34.05
34.06	HAF EXPENSE	A	-2,164,473	ADMINISTRATIVE & GENERAL	5.00	0	34.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,598,547				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: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/16/2017 10:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	274,980	274,980	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	172,775	172,775	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	96,000	96,000	0	0	0	3.00
4.00	50.00	OPERATING ROOM	527,508	527,508	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	136,598	136,598	0	0	0	5.00
6.00	60.00	LABORATORY	115,098	27,830	87,268	260,300	420	6.00
7.00	65.00	RESPIRATORY THERAPY	16,500	16,500	0	0	0	7.00
8.00	88.00	RURAL HEALTH CLINIC	5,490	5,490	0	0	0	8.00
9.00	90.04	ANDIS CLINIC	4,125	4,125	0	0	0	9.00
10.00	90.07	ONCOLOGY	491,162	491,162	0	0	0	10.00
11.00	91.00	EMERGENCY	60,000	60,000	0	0	0	11.00
200.00			1,900,236	1,812,968	87,268		420	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	52,561	2,628	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	8.00
9.00	90.04	ANDIS CLINIC	0	0	0	0	0	9.00
10.00	90.07	ONCOLOGY	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			52,561	2,628	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	274,980		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	172,775		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	96,000		3.00
4.00	50.00	OPERATING ROOM	0	0	0	527,508		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	136,598		5.00
6.00	60.00	LABORATORY	0	52,561	34,707	62,537		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	16,500		7.00
8.00	88.00	RURAL HEALTH CLINIC	0	0	0	5,490		8.00
9.00	90.04	ANDIS CLINIC	0	0	0	4,125		9.00
10.00	90.07	ONCOLOGY	0	0	0	491,162		10.00
11.00	91.00	EMERGENCY	0	0	0	60,000		11.00
200.00			0	52,561	34,707	1,847,675		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	9,252,076	9,252,076				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,138,070	68,177	6,206,247			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,150,572	705,508	1,085,597	14,941,677	14,941,677	5.00
7.00	00700	OPERATION OF PLANT	5,764,784	351,299	149,702	6,265,785	1,151,589	7.00
9.00	00900	HOUSEKEEPING	1,698,894	60,046	154,143	1,913,083	351,606	9.00
10.00	01000	DIETARY	323,631	315,130	67,503	706,264	129,804	10.00
11.00	01100	CAFETERIA	1,395,739	0	124,904	1,520,643	279,479	11.00
13.00	01300	NURSING ADMINISTRATION	1,264,503	0	164,067	1,428,570	262,557	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	86,844	0	10,779	97,623	17,942	14.00
15.00	01500	PHARMACY	9,012,891	51,343	227,720	9,291,954	1,707,742	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	848,848	108,071	100,155	1,057,074	194,280	16.00
23.00	02300	PARAMED ED PRGM	76,122	36,549	15,931	128,602	23,636	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,177,192	618,921	413,737	4,209,850	773,728	30.00
31.00	03100	INTENSIVE CARE UNIT	4,080,338	648,590	528,767	5,257,695	966,312	31.00
40.00	04000	SUBPROVIDER - IPF	1,377,567	173,392	190,078	1,741,037	319,985	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,390,296	683,916	378,690	5,452,902	1,002,189	50.00
51.00	05100	RECOVERY ROOM	260,237	57,652	34,918	352,807	64,842	51.00
53.00	05300	ANESTHESIOLOGY	8,426	0	0	8,426	1,549	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,473,206	706,895	428,819	5,608,920	1,030,863	54.00
60.00	06000	LABORATORY	3,920,357	158,925	252,605	4,331,887	796,158	60.00
65.00	06500	RESPIRATORY THERAPY	1,221,049	64,016	181,871	1,466,936	269,608	65.00
66.00	06600	PHYSICAL THERAPY	1,171,678	105,760	162,223	1,439,661	264,595	66.00
67.00	06700	OCCUPATIONAL THERAPY	331,466	0	47,076	378,542	69,572	67.00
68.00	06800	SPEECH PATHOLOGY	184,637	0	25,577	210,214	38,635	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	795,849	203,769	86,124	1,085,742	199,549	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,236,634	127,597	0	3,364,231	618,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,608,747	0	0	2,608,747	479,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	58,516	61,976	8,193	128,685	23,651	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	337,846	0	15,914	353,760	65,018	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	872,612	78,891	102,617	1,054,120	193,737	90.01
90.02	09002	DIABETES CLINIC	48,002	0	6,438	54,440	10,006	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	69,009	70,815	6,681	146,505	26,926	90.04
90.05	09005	PRIME TIME	100,341	0	0	100,341	18,442	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	422,600	0	41,954	464,554	85,380	90.06
90.07	04951	ONCOLOGY	913,558	377,814	88,396	1,379,768	253,588	90.07
90.08	04950	ANDERSON WOMENS CENTER	291,841	0	39,736	331,577	60,941	90.08
91.00	09100	EMERGENCY	2,851,712	601,136	360,179	3,813,027	700,796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,987,116	294,517	181,273	2,462,906	452,657	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,203,806	6,730,705	5,682,367	85,158,555	12,905,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	516,253	1,990,887	0	2,507,140	460,787	190.01
190.02	19002	PHYSICIAN BUILDING	62,641	0	0	62,641	11,513	190.02
190.03	19003	PRIVATE DUTY	411,239	0	29,444	440,683	80,993	190.03
190.04	19004	MARKETING	699,142	0	18,831	717,973	131,956	190.04
190.05	19005	SPORTS PHYSICALS	56,869	0	8,020	64,889	11,926	190.05
190.06	19006	FOUNDATION	256,815	65,539	33,810	356,164	65,459	190.06
190.07	19007	ASC	2,812	0	0	2,812	517	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	3,410,051	123,490	209,535	3,743,076	687,940	190.09
190.10	19010	HANCOCK WELLNESS	1,283,155	0	123,911	1,407,066	258,605	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	16,622	0	26	16,648	3,060	190.12
190.13	19013	MCCORD WELLNESS	835,889	0	71,575	907,464	166,783	190.13
190.14	19014	3 WEST UNIT	365,993	341,455	28,728	736,176	135,302	190.14

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
190.15	19015	NEUROLOGY PHYSICIAN	79,500	0	0	79,500	14,611	190.15
190.16	19016	THORACI	38,570	0	0	38,570	7,089	190.16
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)	96,239,357	9,252,076	6,206,247	96,239,357	14,941,677	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	7,417,374					7.00
9.00	00900	HOUSEKEEPING	54,802	2,319,491				9.00
10.00	01000	DIETARY	287,611	38,533	1,162,212			10.00
11.00	01100	CAFETERIA	0	63,497	0	1,863,619		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	52,117	1,743,244	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	96,317	0	9,912	11,500	14.00
15.00	01500	PHARMACY	46,860	70,257	0	82,817	96,086	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,634	84,509	0	58,572	0	16.00
23.00	02300	PARAMED ED PRGM	33,358	97,347	0	6,869	7,969	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	564,872	645,858	331,707	173,648	201,471	30.00
31.00	03100	INTENSIVE CARE UNIT	591,950	133,153	483,222	255,630	296,588	31.00
40.00	04000	SUBPROVIDER - IPF	158,251	106,564	268,162	87,085	101,039	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	624,191	258,533	0	134,741	156,330	50.00
51.00	05100	RECOVERY ROOM	52,618	95,198	0	12,969	15,047	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	645,164	94,638	0	191,978	222,739	54.00
60.00	06000	LABORATORY	145,046	90,310	0	142,148	164,924	60.00
65.00	06500	RESPIRATORY THERAPY	58,426	69,168	0	80,523	93,425	65.00
66.00	06600	PHYSICAL THERAPY	96,524	80,387	0	63,011	73,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	20,054	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8,648	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	185,974	0	0	35,180	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,454	156,739	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	56,564	0	0	5,591	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	9,287	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	72,002	0	0	30,795	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	3,673	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	64,631	0	0	3,648	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	15,303	0	90.06
90.07	04951	ONCOLOGY	344,820	0	0	38,573	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	19,549	0	90.08
91.00	09100	EMERGENCY	548,640	138,483	0	157,767	183,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	268,798	0	79,121	81,748	94,847	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,116,190	2,319,491	1,162,212	1,781,836	1,718,118	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	1,817,026	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	21,656	25,126	190.03
190.04	19004	MARKETING	0	0	0	7,598	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	4,441	0	190.05
190.06	19006	FOUNDATION	59,816	0	0	15,742	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	112,706	0	0	20,797	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	7	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	311,636	0	0	11,542	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	9.00	10.00	11.00	13.00	
202.00	TOTAL (sum lines 118-201)	7,417,374	2,319,491	1,162,212	1,863,619	1,743,244	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	233,294					14.00
15.00	01500	PHARMACY	4,999	11,300,715				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,493,069			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	297,781		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,262	0	401,642	0	7,307,038	30.00
31.00	03100	INTENSIVE CARE UNIT	9,180	0	50,150	0	8,043,880	31.00
40.00	04000	SUBPROVIDER - IPF	690	0	41,352	0	2,824,165	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,105	0	527,897	0	8,166,888	50.00
51.00	05100	RECOVERY ROOM	310	0	0	0	593,791	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,975	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,424	0	60,268	297,781	8,154,775	54.00
60.00	06000	LABORATORY	53,965	0	133,734	0	5,858,172	60.00
65.00	06500	RESPIRATORY THERAPY	670	0	0	0	2,038,756	65.00
66.00	06600	PHYSICAL THERAPY	93	0	0	0	2,017,378	66.00
67.00	06700	OCCUPATIONAL THERAPY	90	0	0	0	468,258	67.00
68.00	06800	SPEECH PATHOLOGY	106	0	0	0	257,603	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	839	0	68,627	0	1,575,911	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	132,156	0	0	0	4,387,892	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,088,209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,300,715	3,079	0	11,303,794	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	34	0	0	0	214,525	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	613	0	0	0	428,678	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	686	0	0	0	1,351,340	90.01
90.02	09002	DIABETES CLINIC	7	0	0	0	68,126	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	4	0	0	0	241,714	90.04
90.05	09005	PRIME TIME	0	0	0	0	118,783	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	282	0	0	0	565,519	90.06
90.07	04951	ONCOLOGY	987	0	0	0	2,017,736	90.07
90.08	04950	ANDERSON WOMENS CENTER	175	0	0	0	412,242	90.08
91.00	09100	EMERGENCY	8,239	0	206,320	0	5,756,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	2,038	0	0	0	3,442,115	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	232,954	11,300,715	1,493,069	297,781	80,713,581	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	4,784,953	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	74,154	190.02
190.03	19003	PRIVATE DUTY	135	0	0	0	568,593	190.03
190.04	19004	MARKETING	0	0	0	0	857,527	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	81,256	190.05
190.06	19006	FOUNDATION	0	0	0	0	497,181	190.06
190.07	19007	ASC	0	0	0	0	3,329	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	184	0	0	0	4,564,703	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	1,665,671	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	19,715	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	1,074,247	190.13
190.14	19014	3 WEST UNIT	21	0	0	0	1,194,677	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	94,111	190.15
190.16	19016	THORACI	0	0	0	0	45,659	190.16
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: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
		14.00	15.00	16.00	23.00	24.00	
202.00	TOTAL (sum lines 118-201)	233,294	11,300,715	1,493,069	297,781	96,239,357	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
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
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,307,038		30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,043,880		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,824,165		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,166,888		50.00
51.00	05100	RECOVERY ROOM	0	593,791		51.00
53.00	05300	ANESTHESIOLOGY	0	9,975		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,154,775		54.00
60.00	06000	LABORATORY	0	5,858,172		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,038,756		65.00
66.00	06600	PHYSICAL THERAPY	0	2,017,378		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	468,258		67.00
68.00	06800	SPEECH PATHOLOGY	0	257,603		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	1,575,911		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,387,892		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,088,209		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,303,794		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	214,525		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	428,678		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	1,351,340		90.01
90.02	09002	DIABETES CLINIC	0	68,126		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	241,714		90.04
90.05	09005	PRIME TIME	0	118,783		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	565,519		90.06
90.07	04951	ONCOLOGY	0	2,017,736		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	412,242		90.08
91.00	09100	EMERGENCY	0	5,756,318		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	3,442,115		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	80,713,581		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	4,784,953		190.01
190.02	19002	PHYSICIAN BUILDING	0	74,154		190.02
190.03	19003	PRIVATE DUTY	0	568,593		190.03
190.04	19004	MARKETING	0	857,527		190.04
190.05	19005	SPORTS PHYSICALS	0	81,256		190.05
190.06	19006	FOUNDATION	0	497,181		190.06
190.07	19007	ASC	0	3,329		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.08
190.09	19009	HANCOCK OB	0	4,564,703		190.09
190.10	19010	HANCOCK WELLNESS	0	1,665,671		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	19,715		190.12
190.13	19013	MCCORD WELLNESS	0	1,074,247		190.13
190.14	19014	3 WEST UNIT	0	1,194,677		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	94,111		190.15
190.16	19016	THORACI	0	45,659		190.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	96,239,357	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	68,177	68,177	68,177		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	705,508	705,508	11,918	717,426	5.00
7.00	00700	OPERATION OF PLANT	0	351,299	351,299	1,645	55,296	7.00
9.00	00900	HOUSEKEEPING	0	60,046	60,046	1,694	16,883	9.00
10.00	01000	DIETARY	0	315,130	315,130	742	6,233	10.00
11.00	01100	CAFETERIA	0	0	0	1,372	13,420	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,803	12,607	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	118	862	14.00
15.00	01500	PHARMACY	0	51,343	51,343	2,502	81,971	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	108,071	108,071	1,100	9,329	16.00
23.00	02300	PARAMED ED PRGM	0	36,549	36,549	175	1,135	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	618,921	618,921	4,546	37,152	30.00
31.00	03100	INTENSIVE CARE UNIT	0	648,590	648,590	5,810	46,399	31.00
40.00	04000	SUBPROVIDER - IPF	0	173,392	173,392	2,088	15,365	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	683,916	683,916	4,161	48,122	50.00
51.00	05100	RECOVERY ROOM	0	57,652	57,652	384	3,114	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	74	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	706,895	706,895	4,711	49,499	54.00
60.00	06000	LABORATORY	0	158,925	158,925	2,775	38,229	60.00
65.00	06500	RESPIRATORY THERAPY	0	64,016	64,016	1,998	12,946	65.00
66.00	06600	PHYSICAL THERAPY	0	105,760	105,760	1,782	12,705	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	517	3,341	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	281	1,855	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	203,769	203,769	946	9,582	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	127,597	127,597	0	29,689	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	23,022	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	61,976	61,976	90	1,136	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	175	3,122	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	78,891	78,891	1,127	9,303	90.01
90.02	09002	DIABETES CLINIC	0	0	0	71	480	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	70,815	70,815	73	1,293	90.04
90.05	09005	PRIME TIME	0	0	0	0	886	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	461	4,100	90.06
90.07	04951	ONCOLOGY	0	377,814	377,814	971	12,176	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	437	2,926	90.08
91.00	09100	EMERGENCY	0	601,136	601,136	3,957	33,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	294,517	294,517	1,992	21,735	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	6,730,705	6,730,705	62,422	619,637	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	1,990,887	1,990,887	0	22,126	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	553	190.02
190.03	19003	PRIVATE DUTY	0	0	0	324	3,889	190.03
190.04	19004	MARKETING	0	0	0	207	6,336	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	88	573	190.05
190.06	19006	FOUNDATION	0	65,539	65,539	371	3,143	190.06
190.07	19007	ASC	0	0	0	0	25	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	123,490	123,490	2,302	33,033	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	1,361	12,417	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	147	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	786	8,008	190.13
190.14	19014	3 WEST UNIT	0	341,455	341,455	316	6,497	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	702	190.15

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
190.16	19016	THORACI	0	0	0	0	340	190.16
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	9,252,076	9,252,076	68,177	717,426	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	408,240					7.00
9.00	00900	HOUSEKEEPING	3,016	81,639				9.00
10.00	01000	DIETARY	15,830	1,356	339,291			10.00
11.00	01100	CAFETERIA	0	2,235	0	17,027		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	476	14,886	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,390	0	91	98	14.00
15.00	01500	PHARMACY	2,579	2,473	0	757	820	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,429	2,974	0	535	0	16.00
23.00	02300	PARAMED ED PRGM	1,836	3,426	0	63	68	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,090	22,732	96,837	1,587	1,720	30.00
31.00	03100	INTENSIVE CARE UNIT	32,580	4,687	141,070	2,335	2,534	31.00
40.00	04000	SUBPROVIDER - IPF	8,710	3,751	78,286	796	863	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,354	9,100	0	1,231	1,335	50.00
51.00	05100	RECOVERY ROOM	2,896	3,351	0	118	128	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,509	3,331	0	1,754	1,902	54.00
60.00	06000	LABORATORY	7,983	3,179	0	1,299	1,408	60.00
65.00	06500	RESPIRATORY THERAPY	3,216	2,434	0	736	798	65.00
66.00	06600	PHYSICAL THERAPY	5,313	2,829	0	576	624	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	183	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	79	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	10,236	0	0	321	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,409	5,517	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	3,113	0	0	51	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	85	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	3,963	0	0	281	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	34	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	3,557	0	0	33	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	140	0	90.06
90.07	04951	ONCOLOGY	18,978	0	0	352	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	179	0	90.08
91.00	09100	EMERGENCY	30,196	4,874	0	1,441	1,563	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	14,794	0	23,098	747	810	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	281,587	81,639	339,291	16,280	14,671	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	100,006	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	198	215	190.03
190.04	19004	MARKETING	0	0	0	69	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	41	0	190.05
190.06	19006	FOUNDATION	3,292	0	0	144	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	6,203	0	0	190	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	17,152	0	0	105	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	9.00	10.00	11.00	13.00	
202.00	TOTAL (sum lines 118-201)	408,240	81,639	339,291	17,027	14,886	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	4,559					14.00
15.00	01500	PHARMACY	98	142,543				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	127,438			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	43,252		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83	0	34,281		848,949	30.00
31.00	03100	INTENSIVE CARE UNIT	179	0	4,280		888,464	31.00
40.00	04000	SUBPROVIDER - IPF	13	0	3,530		286,794	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	197	0	45,058		827,474	50.00
51.00	05100	RECOVERY ROOM	6	0	0		67,649	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		74	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47	0	5,144		808,792	54.00
60.00	06000	LABORATORY	1,055	0	11,415		226,268	60.00
65.00	06500	RESPIRATORY THERAPY	13	0	0		86,157	65.00
66.00	06600	PHYSICAL THERAPY	2	0	0		129,591	66.00
67.00	06700	OCCUPATIONAL THERAPY	2	0	0		4,043	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	0		2,217	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		0	68.01
69.00	06900	ELECTROCARDIOLOGY	16	0	5,857		230,727	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,584	0	0		171,796	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		23,022	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	142,543	263		142,806	73.00
76.00	03020	CARDIAC	0	0	0		0	76.00
76.01	03160	CARDIOPULMONARY	1	0	0		66,367	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12	0	0		3,394	88.00
90.00	09000	CLINIC	0	0	0		0	90.00
90.01	09001	WOUND CLINIC	13	0	0		93,578	90.01
90.02	09002	DIABETES CLINIC	0	0	0		585	90.02
90.03	09003	ASTHMA CLINIC	0	0	0		0	90.03
90.04	09004	ANDIS CLINIC	0	0	0		75,771	90.04
90.05	09005	PRIME TIME	0	0	0		886	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	6	0	0		4,707	90.06
90.07	04951	ONCOLOGY	19	0	0		410,310	90.07
90.08	04950	ANDERSON WOMENS CENTER	3	0	0		3,545	90.08
91.00	09100	EMERGENCY	161	0	17,610		694,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	40	0	0		357,733	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,552	142,543	127,438	0	6,456,287	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		2,113,019	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		553	190.02
190.03	19003	PRIVATE DUTY	3	0	0		4,629	190.03
190.04	19004	MARKETING	0	0	0		6,612	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		702	190.05
190.06	19006	FOUNDATION	0	0	0		72,489	190.06
190.07	19007	ASC	0	0	0		25	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		0	190.08
190.09	19009	HANCOCK OB	4	0	0		165,222	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		13,778	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		0	190.11
190.12	19012	O3PUREMED	0	0	0		147	190.12
190.13	19013	MCCORD WELLNESS	0	0	0		8,794	190.13
190.14	19014	3 WEST UNIT	0	0	0		365,525	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		702	190.15
190.16	19016	THORACI	0	0	0		340	190.16
200.00		Cross Foot Adjustments				43,252	43,252	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
		14.00	15.00	16.00	23.00	24.00	
202.00	TOTAL (sum lines 118-201)	4,559	142,543	127,438	43,252	9,252,076	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
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
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	848,949		30.00
31.00	03100	INTENSIVE CARE UNIT	0	888,464		31.00
40.00	04000	SUBPROVIDER - IPF	0	286,794		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	827,474		50.00
51.00	05100	RECOVERY ROOM	0	67,649		51.00
53.00	05300	ANESTHESIOLOGY	0	74		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	808,792		54.00
60.00	06000	LABORATORY	0	226,268		60.00
65.00	06500	RESPIRATORY THERAPY	0	86,157		65.00
66.00	06600	PHYSICAL THERAPY	0	129,591		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,043		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,217		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	230,727		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	171,796		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	23,022		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	142,806		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	66,367		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,394		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	93,578		90.01
90.02	09002	DIABETES CLINIC	0	585		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	75,771		90.04
90.05	09005	PRIME TIME	0	886		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	4,707		90.06
90.07	04951	ONCOLOGY	0	410,310		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	3,545		90.08
91.00	09100	EMERGENCY	0	694,588		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	357,733		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	6,456,287		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	2,113,019		190.01
190.02	19002	PHYSICIAN BUILDING	0	553		190.02
190.03	19003	PRIVATE DUTY	0	4,629		190.03
190.04	19004	MARKETING	0	6,612		190.04
190.05	19005	SPORTS PHYSICALS	0	702		190.05
190.06	19006	FOUNDATION	0	72,489		190.06
190.07	19007	ASC	0	25		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.08
190.09	19009	HANCOCK OB	0	165,222		190.09
190.10	19010	HANCOCK WELLNESS	0	13,778		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	147		190.12
190.13	19013	MCCORD WELLNESS	0	8,794		190.13
190.14	19014	3 WEST UNIT	0	365,525		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	702		190.15
190.16	19016	THORACI	0	340		190.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
200.00	Cross Foot Adjustments	0	43,252		200.00
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	9,252,076		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	340,218					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,507	40,348,031				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,943	7,057,700	-14,941,677	81,297,680		5.00
7.00	00700	OPERATION OF PLANT	12,918	973,239	0	6,265,785	298,850	7.00
9.00	00900	HOUSEKEEPING	2,208	1,002,116	0	1,913,083	2,208	9.00
10.00	01000	DIETARY	11,588	438,851	0	706,264	11,588	10.00
11.00	01100	CAFETERIA	0	812,023	0	1,520,643	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,066,629	0	1,428,570	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	70,078	0	97,623	0	14.00
15.00	01500	PHARMACY	1,888	1,480,453	0	9,291,954	1,888	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,974	651,124	0	1,057,074	3,974	16.00
23.00	02300	PARAMED ED PRGM	1,344	103,569	0	128,602	1,344	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,759	2,689,780	0	4,209,850	22,759	30.00
31.00	03100	INTENSIVE CARE UNIT	23,850	3,437,613	0	5,257,695	23,850	31.00
40.00	04000	SUBPROVIDER - IPF	6,376	1,235,734	0	1,741,037	6,376	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,149	2,461,936	0	5,452,902	25,149	50.00
51.00	05100	RECOVERY ROOM	2,120	227,006	0	352,807	2,120	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,426	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,994	2,787,831	0	5,608,920	25,994	54.00
60.00	06000	LABORATORY	5,844	1,642,235	0	4,331,887	5,844	60.00
65.00	06500	RESPIRATORY THERAPY	2,354	1,182,377	0	1,466,936	2,354	65.00
66.00	06600	PHYSICAL THERAPY	3,889	1,054,640	0	1,439,661	3,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	306,053	0	378,542	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	166,284	0	210,214	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	7,493	559,910	0	1,085,742	7,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,692	0	0	3,364,231	4,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,608,747	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	2,279	53,263	0	128,685	2,279	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	103,458	0	353,760	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	2,901	667,135	0	1,054,120	2,901	90.01
90.02	09002	DIABETES CLINIC	0	41,856	0	54,440	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	2,604	43,437	0	146,505	2,604	90.04
90.05	09005	PRIME TIME	0	0	0	100,341	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	272,752	0	464,554	0	90.06
90.07	04951	ONCOLOGY	13,893	574,681	0	1,379,768	13,893	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	258,334	0	331,577	0	90.08
91.00	09100	EMERGENCY	22,105	2,341,594	0	3,813,027	22,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	10,830	1,178,493	0	2,462,906	10,830	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	247,502	36,942,184	-14,941,677	70,216,878	206,134	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	73,209	0	0	2,507,140	73,209	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	62,641	0	190.02
190.03	19003	PRIVATE DUTY	0	191,424	0	440,683	0	190.03
190.04	19004	MARKETING	0	122,425	0	717,973	0	190.04
190.05	19005	SPORTS PHYSICALS	0	52,141	0	64,889	0	190.05
190.06	19006	FOUNDATION	2,410	219,804	0	356,164	2,410	190.06
190.07	19007	ASC	0	0	0	2,812	0	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	4,541	1,362,229	0	3,743,076	4,541	190.09
190.10	19010	HANCOCK WELLNESS	0	805,568	0	1,407,066	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	166	0	16,648	0	190.12
190.13	19013	MCCORD WELLNESS	0	465,325	0	907,464	0	190.13
190.14	19014	3 WEST UNIT	12,556	186,765	0	736,176	12,556	190.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	79,500	0	190.15
190.16	19016	THORACI	0	0	0	38,570	0	190.16
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)	9,252,076	6,206,247		14,941,677	7,417,374	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.194552	0.153818		0.183790	24.819722	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		68,177		717,426	408,240	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001690		0.008825	1.366036	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	393,860					9.00
10.00	01000	DIETARY	6,543	13,132				10.00
11.00	01100	CAFETERIA	10,782	0	819,939			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	22,930	661,058		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,355	0	4,361	4,361	5,713,437	14.00
15.00	01500	PHARMACY	11,930	0	36,437	36,437	122,415	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,350	0	25,770	0	0	16.00
23.00	02300	PARAMED ED PRGM	16,530	0	3,022	3,022	6	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,670	3,748	76,400	76,400	104,376	30.00
31.00	03100	INTENSIVE CARE UNIT	22,610	5,460	112,470	112,470	224,810	31.00
40.00	04000	SUBPROVIDER - IPF	18,095	3,030	38,315	38,315	16,900	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,900	0	59,282	59,282	247,467	50.00
51.00	05100	RECOVERY ROOM	16,165	0	5,706	5,706	7,585	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,070	0	84,465	84,465	59,374	54.00
60.00	06000	LABORATORY	15,335	0	62,541	62,541	1,321,614	60.00
65.00	06500	RESPIRATORY THERAPY	11,745	0	35,428	35,428	16,404	65.00
66.00	06600	PHYSICAL THERAPY	13,650	0	27,723	27,723	2,274	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	8,823	0	2,214	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,805	0	2,586	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	15,478	0	20,546	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,615	0	0	0	3,236,619	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	2,460	0	829	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	4,086	0	15,023	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	13,549	0	16,793	90.01
90.02	09002	DIABETES CLINIC	0	0	1,616	0	163	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	1,605	0	88	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	6,733	0	6,911	90.06
90.07	04951	ONCOLOGY	0	0	16,971	0	24,161	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	8,601	0	4,276	90.08
91.00	09100	EMERGENCY	23,515	0	69,413	69,413	201,778	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	894	35,967	35,967	49,900	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	393,860	13,132	783,957	651,530	5,705,112	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	9,528	9,528	3,295	190.03
190.04	19004	MARKETING	0	0	3,343	0	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	1,954	0	0	190.05
190.06	19006	FOUNDATION	0	0	6,926	0	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	0	9,150	0	4,516	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	3	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	0	0	5,078	0	514	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
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)	2,319,491	1,162,212	1,863,619	1,743,244	233,294	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.889126	88.502284	2.272875	2.637052	0.040833	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	81,639	339,291	17,027	14,886	4,559	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.207279	25.836963	0.020766	0.022518	0.000798	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,394			16.00
23.00	02300	PARAMED ED PRGM	0	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	913	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	114	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	94	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,200	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137	100		54.00
60.00	06000	LABORATORY	0	304	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	156	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	7	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	469	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	3,394	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		190.02
190.03	19003	PRIVATE DUTY	0	0	0		190.03
190.04	19004	MARKETING	0	0	0		190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		190.05
190.06	19006	FOUNDATION	0	0	0		190.06
190.07	19007	ASC	0	0	0		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.08
190.09	19009	HANCOCK OB	0	0	0		190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		190.11
190.12	19012	O3PUREMED	0	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	0	0		190.13
190.14	19014	3 WEST UNIT	0	0	0		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		190.15
190.16	19016	THORACI	0	0	0		190.16

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/16/2017 10:17 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
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)	11,300,715	1,493,069	297,781		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	113,007.150000	439.914260	2,977.810000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	142,543	127,438	43,252		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,425.430000	37.548026	432.520000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/16/2017 10:17 am

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	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,307,038		7,307,038	0	7,307,038	30.00
31.00	03100	INTENSIVE CARE UNIT	8,043,880		8,043,880	0	8,043,880	31.00
40.00	04000	SUBPROVIDER - IPF	2,824,165		2,824,165	0	2,824,165	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,166,888		8,166,888	0	8,166,888	50.00
51.00	05100	RECOVERY ROOM	593,791		593,791	0	593,791	51.00
53.00	05300	ANESTHESIOLOGY	9,975		9,975	0	9,975	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,154,775		8,154,775	0	8,154,775	54.00
60.00	06000	LABORATORY	5,858,172		5,858,172	34,707	5,892,879	60.00
65.00	06500	RESPIRATORY THERAPY	2,038,756	0	2,038,756	0	2,038,756	65.00
66.00	06600	PHYSICAL THERAPY	2,017,378	0	2,017,378	0	2,017,378	66.00
67.00	06700	OCCUPATIONAL THERAPY	468,258	0	468,258	0	468,258	67.00
68.00	06800	SPEECH PATHOLOGY	257,603	0	257,603	0	257,603	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,575,911		1,575,911	0	1,575,911	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,387,892		4,387,892	0	4,387,892	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,088,209		3,088,209	0	3,088,209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,303,794		11,303,794	0	11,303,794	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	214,525		214,525	0	214,525	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	428,678		428,678	0	428,678	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,351,340		1,351,340	0	1,351,340	90.01
90.02	09002	DIABETES CLINIC	68,126		68,126	0	68,126	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	241,714		241,714	0	241,714	90.04
90.05	09005	PRIME TIME	118,783		118,783	0	118,783	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	565,519		565,519	0	565,519	90.06
90.07	04951	ONCOLOGY	2,017,736		2,017,736	0	2,017,736	90.07
90.08	04950	ANDERSON WOMENS CENTER	412,242		412,242	0	412,242	90.08
91.00	09100	EMERGENCY	5,756,318		5,756,318	0	5,756,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	199,002		199,002		199,002	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,442,115		3,442,115		3,442,115	116.00
200.00		Subtotal (see instructions)	80,912,583	0	80,912,583	34,707	80,947,290	200.00
201.00		Less Observation Beds	199,002		199,002		199,002	201.00
202.00		Total (see instructions)	80,713,581	0	80,713,581	34,707	80,748,288	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,982,171		6,982,171			30.00
31.00	03100	INTENSIVE CARE UNIT	11,690,903		11,690,903			31.00
40.00	04000	SUBPROVIDER - IPF	3,793,506		3,793,506			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,535,877	12,131,853	21,667,730	0.376915	0.000000	50.00
51.00	05100	RECOVERY ROOM	946,469	1,294,270	2,240,739	0.264998	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	18,191	955	19,146	0.520997	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,416,494	55,005,978	59,422,472	0.137234	0.000000	54.00
60.00	06000	LABORATORY	6,618,167	32,054,880	38,673,047	0.151479	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,302,624	4,991,355	8,293,979	0.245812	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	861,015	4,021,779	4,882,794	0.413161	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	579,839	749,145	1,328,984	0.352343	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	122,914	471,207	594,121	0.433587	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	5,244,568	9,160,494	14,405,062	0.109400	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,124,682	3,261,448	5,386,130	0.814665	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,345,656	1,171,814	7,517,470	0.410804	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,527,994	41,215,394	50,743,388	0.222764	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	350,776	350,776	0.611573	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	398,980	398,980			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	17,600	3,482,687	3,500,287	0.386065	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	54,209	54,209	1.256729	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	42,703	42,703	5.660352	0.000000	90.04
90.05	09005	PRIME TIME	55	365,310	365,365	0.325108	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	1,865	1,745,992	1,747,857	0.323550	0.000000	90.06
90.07	04951	ONCOLOGY	21,597	3,970,171	3,991,768	0.505474	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	12,488	3,070,026	3,082,514	0.133736	0.000000	90.08
91.00	09100	EMERGENCY	4,290,926	31,521,931	35,812,857	0.160733	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	139,021	2,525,202	2,664,223	0.074694	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	891,208	1,732,089	2,623,297			116.00
200.00		Subtotal (see instructions)	77,485,830	214,790,648	292,276,478			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	77,485,830	214,790,648	292,276,478			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.376915	50.00
51.00	05100	RECOVERY ROOM	0.264998	51.00
53.00	05300	ANESTHESIOLOGY	0.520997	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137234	54.00
60.00	06000	LABORATORY	0.152377	60.00
65.00	06500	RESPIRATORY THERAPY	0.245812	65.00
66.00	06600	PHYSICAL THERAPY	0.413161	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352343	67.00
68.00	06800	SPEECH PATHOLOGY	0.433587	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0.109400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.814665	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.410804	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222764	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.611573	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.386065	90.01
90.02	09002	DIABETES CLINIC	1.256729	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	5.660352	90.04
90.05	09005	PRIME TIME	0.325108	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.323550	90.06
90.07	04951	ONCOLOGY	0.505474	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.133736	90.08
91.00	09100	EMERGENCY	0.160733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.074694	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
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: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/16/2017 10:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,307,038		7,307,038	0	7,307,038	30.00
31.00	03100	INTENSIVE CARE UNIT	8,043,880		8,043,880	0	8,043,880	31.00
40.00	04000	SUBPROVIDER - IPF	2,824,165		2,824,165	0	2,824,165	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,166,888		8,166,888	0	8,166,888	50.00
51.00	05100	RECOVERY ROOM	593,791		593,791	0	593,791	51.00
53.00	05300	ANESTHESIOLOGY	9,975		9,975	0	9,975	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,154,775		8,154,775	0	8,154,775	54.00
60.00	06000	LABORATORY	5,858,172		5,858,172	34,707	5,892,879	60.00
65.00	06500	RESPIRATORY THERAPY	2,038,756	0	2,038,756	0	2,038,756	65.00
66.00	06600	PHYSICAL THERAPY	2,017,378	0	2,017,378	0	2,017,378	66.00
67.00	06700	OCCUPATIONAL THERAPY	468,258	0	468,258	0	468,258	67.00
68.00	06800	SPEECH PATHOLOGY	257,603	0	257,603	0	257,603	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,575,911		1,575,911	0	1,575,911	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,387,892		4,387,892	0	4,387,892	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,088,209		3,088,209	0	3,088,209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,303,794		11,303,794	0	11,303,794	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	214,525		214,525	0	214,525	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	428,678		428,678	0	428,678	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,351,340		1,351,340	0	1,351,340	90.01
90.02	09002	DIABETES CLINIC	68,126		68,126	0	68,126	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	241,714		241,714	0	241,714	90.04
90.05	09005	PRIME TIME	118,783		118,783	0	118,783	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	565,519		565,519	0	565,519	90.06
90.07	04951	ONCOLOGY	2,017,736		2,017,736	0	2,017,736	90.07
90.08	04950	ANDERSON WOMENS CENTER	412,242		412,242	0	412,242	90.08
91.00	09100	EMERGENCY	5,756,318		5,756,318	0	5,756,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	199,002		199,002		199,002	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,442,115		3,442,115		3,442,115	116.00
200.00		Subtotal (see instructions)	80,912,583	0	80,912,583	34,707	80,947,290	200.00
201.00		Less Observation Beds	199,002		199,002		199,002	201.00
202.00		Total (see instructions)	80,713,581	0	80,713,581	34,707	80,748,288	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/16/2017 10:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,982,171		6,982,171			30.00
31.00	03100	INTENSIVE CARE UNIT	11,690,903		11,690,903			31.00
40.00	04000	SUBPROVIDER - IPF	3,793,506		3,793,506			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,535,877	12,131,853	21,667,730	0.376915	0.000000	50.00
51.00	05100	RECOVERY ROOM	946,469	1,294,270	2,240,739	0.264998	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	18,191	955	19,146	0.520997	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,416,494	55,005,978	59,422,472	0.137234	0.000000	54.00
60.00	06000	LABORATORY	6,618,167	32,054,880	38,673,047	0.151479	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,302,624	4,991,355	8,293,979	0.245812	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	861,015	4,021,779	4,882,794	0.413161	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	579,839	749,145	1,328,984	0.352343	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	122,914	471,207	594,121	0.433587	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	5,244,568	9,160,494	14,405,062	0.109400	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,124,682	3,261,448	5,386,130	0.814665	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,345,656	1,171,814	7,517,470	0.410804	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,527,994	41,215,394	50,743,388	0.222764	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	350,776	350,776	0.611573	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	398,980	398,980	1.074435	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	17,600	3,482,687	3,500,287	0.386065	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	54,209	54,209	1.256729	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	42,703	42,703	5.660352	0.000000	90.04
90.05	09005	PRIME TIME	55	365,310	365,365	0.325108	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	1,865	1,745,992	1,747,857	0.323550	0.000000	90.06
90.07	04951	ONCOLOGY	21,597	3,970,171	3,991,768	0.505474	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	12,488	3,070,026	3,082,514	0.133736	0.000000	90.08
91.00	09100	EMERGENCY	4,290,926	31,521,931	35,812,857	0.160733	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	139,021	2,525,202	2,664,223	0.074694	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	891,208	1,732,089	2,623,297			116.00
200.00		Subtotal (see instructions)	77,485,830	214,790,648	292,276,478			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	77,485,830	214,790,648	292,276,478			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/16/2017 10:17 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC	0.000000		76.00
76.01	03160	CARDIOPULMONARY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINIC	0.000000		90.01
90.02	09002	DIABETES CLINIC	0.000000		90.02
90.03	09003	ASTHMA CLINIC	0.000000		90.03
90.04	09004	ANDIS CLINIC	0.000000		90.04
90.05	09005	PRIME TIME	0.000000		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000		90.06
90.07	04951	ONCOLOGY	0.000000		90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000		90.08
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
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: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	848,949	0	848,949	3,782	224.47	30.00
31.00	INTENSIVE CARE UNIT	888,464		888,464	5,460	162.72	31.00
40.00	SUBPROVIDER - IPF	286,794	0	286,794	3,030	94.65	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
200.00	Total (lines 30-199)	2,024,207		2,024,207	12,272		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	1,059	237,714	30.00
31.00	INTENSIVE CARE UNIT	2,587	420,957	31.00
40.00	SUBPROVIDER - IPF	2,739	259,246	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
200.00	Total (lines 30-199)	6,385	917,917	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	827,474	21,667,730	0.038189	3,332,117	127,250	50.00
51.00	05100	RECOVERY ROOM	67,649	2,240,739	0.030190	382,255	11,540	51.00
53.00	05300	ANESTHESIOLOGY	74	19,146	0.003865	1,432	6	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	808,792	59,422,472	0.013611	2,509,532	34,157	54.00
60.00	06000	LABORATORY	226,268	38,673,047	0.005851	3,250,032	19,016	60.00
65.00	06500	RESPIRATORY THERAPY	86,157	8,293,979	0.010388	1,781,905	18,510	65.00
66.00	06600	PHYSICAL THERAPY	129,591	4,882,794	0.026540	449,515	11,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,043	1,328,984	0.003042	270,093	822	67.00
68.00	06800	SPEECH PATHOLOGY	2,217	594,121	0.003732	77,101	288	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	230,727	14,405,062	0.016017	1,941,833	31,102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	171,796	5,386,130	0.031896	932,014	29,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	23,022	7,517,470	0.003062	3,016,015	9,235	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,806	50,743,388	0.002814	4,064,228	11,437	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	66,367	350,776	0.189201	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,394	398,980	0.008507	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	93,578	3,500,287	0.026734	4,798	128	90.01
90.02	09002	DIABETES CLINIC	585	54,209	0.010792	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	75,771	42,703	1.774372	0	0	90.04
90.05	09005	PRIME TIME	886	365,365	0.002425	48	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	4,707	1,747,857	0.002693	0	0	90.06
90.07	04951	ONCOLOGY	410,310	3,991,768	0.102789	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	3,545	3,082,514	0.001150	8,232	9	90.08
91.00	09100	EMERGENCY	694,588	35,812,857	0.019395	2,624,494	50,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,120	2,664,223	0.008678	103	1	92.00
200.00		Total (lines 50-199)	4,097,467	267,186,601		24,645,747	356,061	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/16/2017 10:17 am

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		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	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
200.00		Total (lines 30-199)	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	3,782	0.00	1,059	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,460	0.00	2,587	0		31.00
40.00	04000	SUBPROVIDER - IPF	3,030	0.00	2,739	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
200.00		Total (lines 30-199)	12,272		6,385	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Hospital | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	297,781	0	297,781	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	297,781	0	297,781	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/16/2017 10:17 am

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		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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,667,730	0.000000	0.000000	3,332,117	50.00
51.00	05100	RECOVERY ROOM	0	2,240,739	0.000000	0.000000	382,255	51.00
53.00	05300	ANESTHESIOLOGY	0	19,146	0.000000	0.000000	1,432	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	297,781	59,422,472	0.005011	0.005011	2,509,532	54.00
60.00	06000	LABORATORY	0	38,673,047	0.000000	0.000000	3,250,032	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,293,979	0.000000	0.000000	1,781,905	65.00
66.00	06600	PHYSICAL THERAPY	0	4,882,794	0.000000	0.000000	449,515	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,328,984	0.000000	0.000000	270,093	67.00
68.00	06800	SPEECH PATHOLOGY	0	594,121	0.000000	0.000000	77,101	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	14,405,062	0.000000	0.000000	1,941,833	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,386,130	0.000000	0.000000	932,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,517,470	0.000000	0.000000	3,016,015	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,743,388	0.000000	0.000000	4,064,228	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03160	CARDIOPULMONARY	0	350,776	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	398,980	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CLINIC	0	3,500,287	0.000000	0.000000	4,798	90.01
90.02	09002	DIABETES CLINIC	0	54,209	0.000000	0.000000	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ANDIS CLINIC	0	42,703	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	365,365	0.000000	0.000000	48	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,747,857	0.000000	0.000000	0	90.06
90.07	04951	ONCOLOGY	0	3,991,768	0.000000	0.000000	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	3,082,514	0.000000	0.000000	8,232	90.08
91.00	09100	EMERGENCY	0	35,812,857	0.000000	0.000000	2,624,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,664,223	0.000000	0.000000	103	92.00
200.00		Total (lines 50-199)	297,781	267,186,601			24,645,747	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Hospital | 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		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,575,191	0		50.00
51.00	05100	RECOVERY ROOM	0	283,950	0		51.00
53.00	05300	ANESTHESIOLOGY	0	728	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,575	15,416,169	77,250		54.00
60.00	06000	LABORATORY	0	4,420,474	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,437,620	0		65.00
66.00	06600	PHYSICAL THERAPY	0	41,494	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	24,375	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	48,446	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	3,917,537	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	816,115	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	278,205	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,333,850	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	150,102	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	2,320,692	0		90.01
90.02	09002	DIABETES CLINIC	0	47	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	3,238	0		90.04
90.05	09005	PRIME TIME	0	20,492	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	304,721	0		90.06
90.07	04951	ONCOLOGY	0	552,186	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	639	0		90.08
91.00	09100	EMERGENCY	0	6,331,038	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,635,243	0		92.00
200.00		Total (lines 50-199)	12,575	51,912,552	77,250		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.376915	2,575,191	0	0	970,628	50.00
51.00	05100	RECOVERY ROOM	0.264998	283,950	0	0	75,246	51.00
53.00	05300	ANESTHESIOLOGY	0.520997	728	0	0	379	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137234	15,416,169	0	0	2,115,623	54.00
60.00	06000	LABORATORY	0.151479	4,420,474	78	0	669,609	60.00
65.00	06500	RESPIRATORY THERAPY	0.245812	1,437,620	0	0	353,384	65.00
66.00	06600	PHYSICAL THERAPY	0.413161	41,494	0	0	17,144	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352343	24,375	0	0	8,588	67.00
68.00	06800	SPEECH PATHOLOGY	0.433587	48,446	0	0	21,006	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.109400	3,917,537	0	0	428,579	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.814665	816,115	0	0	664,860	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.410804	278,205	0	0	114,288	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222764	11,333,850	269	25,043	2,524,774	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.611573	150,102	0	0	91,798	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.386065	2,320,692	0	0	895,938	90.01
90.02	09002	DIABETES CLINIC	1.256729	47	0	0	59	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	5.660352	3,238	0	0	18,328	90.04
90.05	09005	PRIME TIME	0.325108	20,492	0	0	6,662	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.323550	304,721	0	0	98,592	90.06
90.07	04951	ONCOLOGY	0.505474	552,186	0	0	279,116	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.133736	639	0	0	85	90.08
91.00	09100	EMERGENCY	0.160733	6,331,038	0	0	1,017,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.074694	1,635,243	0	0	122,143	92.00
200.00		Subtotal (see instructions)		51,912,552	347	25,043	10,494,436	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		51,912,552	347	25,043	10,494,436	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	12	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60	5,579		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0		90.04
90.05	09005	PRIME TIME	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		90.06
90.07	04951	ONCOLOGY	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0		90.08
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	72	5,579		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	72	5,579		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II | Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	827,474	21,667,730	0.038189	33,407	1,276	50.00
51.00	05100	RECOVERY ROOM	67,649	2,240,739	0.030190	3,472	105	51.00
53.00	05300	ANESTHESIOLOGY	74	19,146	0.003865	39	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	808,792	59,422,472	0.013611	101,051	1,375	54.00
60.00	06000	LABORATORY	226,268	38,673,047	0.005851	422,870	2,474	60.00
65.00	06500	RESPIRATORY THERAPY	86,157	8,293,979	0.010388	179,886	1,869	65.00
66.00	06600	PHYSICAL THERAPY	129,591	4,882,794	0.026540	63,356	1,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,043	1,328,984	0.003042	108,801	331	67.00
68.00	06800	SPEECH PATHOLOGY	2,217	594,121	0.003732	18,431	69	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	230,727	14,405,062	0.016017	15,820	253	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	171,796	5,386,130	0.031896	56,344	1,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	23,022	7,517,470	0.003062	13,632	42	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,806	50,743,388	0.002814	387,491	1,090	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	66,367	350,776	0.189201	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,394	398,980	0.008507	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	93,578	3,500,287	0.026734	2,281	61	90.01
90.02	09002	DIABETES CLINIC	585	54,209	0.010792	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	75,771	42,703	1.774372	0	0	90.04
90.05	09005	PRIME TIME	886	365,365	0.002425	7	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	4,707	1,747,857	0.002693	0	0	90.06
90.07	04951	ONCOLOGY	410,310	3,991,768	0.102789	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	3,545	3,082,514	0.001150	4,256	5	90.08
91.00	09100	EMERGENCY	694,588	35,812,857	0.019395	63,832	1,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,664,223	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,074,347	267,186,601		1,474,976	13,666	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/16/2017 10:17 am

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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	297,781	0	297,781	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	297,781	0	297,781	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/16/2017 10:17 am

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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,667,730	0.000000	0.000000	33,407	50.00
51.00	05100	RECOVERY ROOM	0	2,240,739	0.000000	0.000000	3,472	51.00
53.00	05300	ANESTHESIOLOGY	0	19,146	0.000000	0.000000	39	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	297,781	59,422,472	0.005011	0.005011	101,051	54.00
60.00	06000	LABORATORY	0	38,673,047	0.000000	0.000000	422,870	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,293,979	0.000000	0.000000	179,886	65.00
66.00	06600	PHYSICAL THERAPY	0	4,882,794	0.000000	0.000000	63,356	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,328,984	0.000000	0.000000	108,801	67.00
68.00	06800	SPEECH PATHOLOGY	0	594,121	0.000000	0.000000	18,431	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	14,405,062	0.000000	0.000000	15,820	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,386,130	0.000000	0.000000	56,344	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,517,470	0.000000	0.000000	13,632	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,743,388	0.000000	0.000000	387,491	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03160	CARDIOPULMONARY	0	350,776	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	398,980	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CLINIC	0	3,500,287	0.000000	0.000000	2,281	90.01
90.02	09002	DIABETES CLINIC	0	54,209	0.000000	0.000000	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ANDIS CLINIC	0	42,703	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	365,365	0.000000	0.000000	7	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,747,857	0.000000	0.000000	0	90.06
90.07	04951	ONCOLOGY	0	3,991,768	0.000000	0.000000	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	3,082,514	0.000000	0.000000	4,256	90.08
91.00	09100	EMERGENCY	0	35,812,857	0.000000	0.000000	63,832	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,664,223	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	297,781	267,186,601			1,474,976	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/16/2017 10:17 am

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		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	506	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	506	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,782	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,782	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)	3,679	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)	1,059	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,307,038	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)	7,307,038	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,307,038	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,932.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,046,052	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,046,052	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/16/2017 10:17 am

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	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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,043,880	5,460	1,473.24	2,587	3,811,272	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)	6,490,813	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,348,137	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)	658,671	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	368,636	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,027,307	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,320,830	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)	103	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,932.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	199,002	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/16/2017 10:17 am

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	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	848,949	7,307,038	0.116182	199,002	23,120	90.00
91.00	Nursing School cost	0	7,307,038	0.000000	199,002	0	91.00
92.00	Allied health cost	0	7,307,038	0.000000	199,002	0	92.00
93.00	All other Medical Education	0	7,307,038	0.000000	199,002	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037 Component CCN: 15-S037	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/16/2017 10:17 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,030	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,030	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)	3,030	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)	2,739	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,824,165	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)	2,824,165	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,824,165	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	932.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,552,940	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,552,940	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	359,819	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,912,759	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)	259,246	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	14,172	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	273,418	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,639,341	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1

Component CCN: 15-S037 | Date/Time Prepared: 5/16/2017 10:17 am

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	286,794	2,824,165	0.101550	0	0	90.00
91.00	Nursing School cost	0	2,824,165	0.000000	0	0	91.00
92.00	Allied health cost	0	2,824,165	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,824,165	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/16/2017 10:17 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,782	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,782	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)	3,679	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)	23	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,307,038	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)	7,307,038	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,307,038	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,932.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	44,437	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)	44,437	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/16/2017 10:17 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,043,880	5,460	1,473.24	8	11,786	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)	27,053	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	83,276	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	103	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,932.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	199,002	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/16/2017 10:17 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	848,949	7,307,038	0.116182	199,002	23,120	90.00
91.00	Nursing School cost	0	7,307,038	0.000000	199,002	0	91.00
92.00	Allied health cost	0	7,307,038	0.000000	199,002	0	92.00
93.00	All other Medical Education	0	7,307,038	0.000000	199,002	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		999,314		30.00
31.00	03100	INTENSIVE CARE UNIT		5,505,906		31.00
40.00	04000	SUBPROVIDER - IPF		21,013		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.376915	3,332,117	1,255,925	50.00
51.00	05100	RECOVERY ROOM	0.264998	382,255	101,297	51.00
53.00	05300	ANESTHESIOLOGY	0.520997	1,432	746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137234	2,509,532	344,393	54.00
60.00	06000	LABORATORY	0.152377	3,250,032	495,230	60.00
65.00	06500	RESPIRATORY THERAPY	0.245812	1,781,905	438,014	65.00
66.00	06600	PHYSICAL THERAPY	0.413161	449,515	185,722	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352343	270,093	95,165	67.00
68.00	06800	SPEECH PATHOLOGY	0.433587	77,101	33,430	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.109400	1,941,833	212,437	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.814665	932,014	759,279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.410804	3,016,015	1,238,991	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222764	4,064,228	905,364	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.611573	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.386065	4,798	1,852	90.01
90.02	09002	DIABETES CLINIC	1.256729	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	5.660352	0	0	90.04
90.05	09005	PRIME TIME	0.325108	48	16	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.323550	0	0	90.06
90.07	04951	ONCOLOGY	0.505474	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.133736	8,232	1,101	90.08
91.00	09100	EMERGENCY	0.160733	2,624,494	421,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.074694	103	8	92.00
200.00		Total (sum of lines 50-94 and 96-98)		24,645,747	6,490,813	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)		24,645,747		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/16/2017 10:17 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		3,415,009		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.376915	33,407	12,592	50.00
51.00	05100	RECOVERY ROOM	0.264998	3,472	920	51.00
53.00	05300	ANESTHESIOLOGY	0.520997	39	20	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137234	101,051	13,868	54.00
60.00	06000	LABORATORY	0.152377	422,870	64,436	60.00
65.00	06500	RESPIRATORY THERAPY	0.245812	179,886	44,218	65.00
66.00	06600	PHYSICAL THERAPY	0.413161	63,356	26,176	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352343	108,801	38,335	67.00
68.00	06800	SPEECH PATHOLOGY	0.433587	18,431	7,991	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.109400	15,820	1,731	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.814665	56,344	45,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.410804	13,632	5,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222764	387,491	86,319	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.611573	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.386065	2,281	881	90.01
90.02	09002	DIABETES CLINIC	1.256729	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	5.660352	0	0	90.04
90.05	09005	PRIME TIME	0.325108	7	2	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.323550	0	0	90.06
90.07	04951	ONCOLOGY	0.505474	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.133736	4,256	569	90.08
91.00	09100	EMERGENCY	0.160733	63,832	10,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.074694	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,474,976	359,819	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)		1,474,976		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/16/2017 10:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		37,554		30.00
31.00	03100	INTENSIVE CARE UNIT		17,543		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.376915	22,949	8,650	50.00
51.00	05100	RECOVERY ROOM	0.264998	2,240	594	51.00
53.00	05300	ANESTHESIOLOGY	0.520997	72	38	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137234	7,811	1,072	54.00
60.00	06000	LABORATORY	0.151479	13,470	2,040	60.00
65.00	06500	RESPIRATORY THERAPY	0.245812	5,576	1,371	65.00
66.00	06600	PHYSICAL THERAPY	0.413161	749	309	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352343	401	141	67.00
68.00	06800	SPEECH PATHOLOGY	0.433587	70	30	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.109400	8,589	940	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.814665	6,212	5,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.410804	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.222764	23,976	5,341	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.611573	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.074435	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.386065	7	3	90.01
90.02	09002	DIABETES CLINIC	1.256729	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	5.660352	0	0	90.04
90.05	09005	PRIME TIME	0.325108	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.323550	0	0	90.06
90.07	04951	ONCOLOGY	0.505474	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.133736	0	0	90.08
91.00	09100	EMERGENCY	0.160733	9,102	1,463	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.074694	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		101,224	27,053	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)		101,224		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/16/2017 10:17 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	6,805,799	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,311,378	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)	38,625	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)	60.72	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA 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
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
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
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.84	30.00
31.00	Percentage of Medicaid patient days (see instructions)	14.42	31.00
32.00	Sum of lines 30 and 31	16.26	32.00
33.00	Allowable disproportionate share percentage (see instructions)	3.32	33.00
34.00	Disproportionate share adjustment (see instructions)	75,673	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/16/2017 10:17 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000038334	0.000039044	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	245,574	233,383	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	183,845	58,825	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	242,670		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	9,474,145		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	9,474,145	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	734,573	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	7,495	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 intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	12,575	58.00
59.00	Total (sum of amounts on lines 49 through 58)	10,228,788	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,228,788	61.00
62.00	Deductibles billed to program beneficiaries	1,189,860	62.00
63.00	Coinsurance billed to program beneficiaries	12,236	63.00
64.00	Allowable bad debts (see instructions)	82,563	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	53,666	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	82,563	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,080,358	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)	29,399	70.93
70.94	HRR adjustment amount (see instructions)	-4,135	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/16/2017 10:17 am
	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)	2016	244,733	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)	2017	101,476	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,451,831	71.00
71.01	Sequestration adjustment (see instructions)		189,037	71.01
72.00	Interim payments		9,201,984	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)		60,810	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,026,694	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/16/2017 10:17 am

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	6,805,799	0	6,805,799		6,805,799	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,311,378	0		2,311,378	2,311,378	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	38,625	0	21,659	16,966	38,625	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
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0332	0.0332	0.0332	0.0332		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	75,673	0	56,488	19,185	75,673	11.00
11.01	Uncompensated care payments	36.00	242,670	0	183,845	58,825	242,670	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,474,145	0	7,067,791	2,406,354	9,474,145	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	9,474,145	0	7,067,791	2,406,354	9,474,145	15.00
16.00	Payment for inpatient program capital	50.00	734,573	0	546,093	188,480	734,573	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/16/2017 10:17 am

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	7,613,884	2,594,834	10,208,718	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	732,940	0	545,752	187,188	732,940	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	1,633	0	341	1,292	1,633	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	734,573	0	546,093	188,480	734,573	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				0.032143	0.039107		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			244,733		244,733	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				101,476	101,476	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/16/2017 10:17 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,805,799	6,805,799		6,805,799	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,311,378		2,311,378	2,311,378	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	38,625	21,659	16,965	38,624	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
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0332	0.0332	0.0332		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	75,673	56,488	19,185	75,673	11.00
11.01	Uncompensated care payments	36.00	242,670	183,845	58,825	242,670	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,474,145	7,067,792	2,406,353	9,474,145	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	9,474,145	7,067,792	2,406,353	9,474,145	15.00
16.00	Payment for inpatient program capital	50.00	734,573	546,093	188,480	734,573	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	SUBTOTAL			7,613,885	2,594,833	10,208,718	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/16/2017 10:17 am

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	732,940	545,752	187,188	732,940	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	1,633	341	1,292	1,633	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	734,573	546,093	188,480	734,573	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	244,733	244,733		244,733	28.00
29.00	Low volume adjustment on or after October 1	70.97	101,476		101,476	101,476	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	29,399	13,507	15,892	29,399	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	-4,135	-1,361	-2,774	-4,135	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/16/2017 10:17 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,651	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,417,186	2.00
3.00	PPS payments	8,861,420	3.00
4.00	Outlier payment (see instructions)	19,997	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	77,250	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,651	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	25,390	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)	25,390	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	25,390	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	19,739	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)	5,651	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)	8,958,667	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
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)	1,885,454	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)	7,078,864	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)	7,078,864	30.00
31.00	Primary payer payments	1,694	31.00
32.00	Subtotal (line 30 minus line 31)	7,077,170	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	166,872	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	108,467	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	166,872	36.00
37.00	Subtotal (see instructions)	7,185,637	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)	7,185,637	40.00
40.01	Sequestration adjustment (see instructions)	143,713	40.01
41.00	Interim payments	6,989,121	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	52,803	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/16/2017 10:17 am

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		9,201,984		6,855,426	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	12/31/2016	133,695	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		133,695	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,201,984		6,989,121	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		60,810		52,803	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,262,794		7,041,924	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: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/16/2017 10:17 am

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		2,474,017		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,474,017		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		498		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,474,515		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0037	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/16/2017 10:17 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,714	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,646	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	737	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	9,139	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	292,276,478	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,383,686	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
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
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: 15-0037 Component CCN: 15-S037	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/16/2017 10:17 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,669,337	1.00
2.00	Net IPF PPS Outlier Payments	23,760	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	8.278689	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,693,097	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,693,097	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,693,097	18.00
19.00	Deductibles	155,708	19.00
20.00	Subtotal (line 18 minus line 19)	2,537,389	20.00
21.00	Coinsurance	12,880	21.00
22.00	Subtotal (line 20 minus line 21)	2,524,509	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,524,509	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)	506	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)	2,525,015	31.00
31.01	Sequestration adjustment (see instructions)	50,500	31.01
32.00	Interim payments	2,474,017	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)	498	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	23,760	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: 15-0037	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/16/2017 10:17 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	83,276		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	83,276	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	83,276	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	54,875		8.00
9.00	Ancillary service charges	101,224	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	156,099	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	156,099	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	72,823	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	83,276	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	83,276	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	83,276	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	83,276	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	83,276	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	83,276	0	40.00
41.00	Interim payments	76,416	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	6,860	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/16/2017 10:17 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,221,106	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,526,759	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	22,893,568	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	62,069,515	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)	104,710,948	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	9,394,466	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	113,321,538	0	0	0	15.00
16.00	Accumulated depreciation	-129,025,483	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	75,917,586	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	69,608,107	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8,050,336	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,050,336	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	182,369,391	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,612,673	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,948,401	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,191,808	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,752,882	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,752,882	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	168,616,509				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	168,616,509	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	182,369,391	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/16/2017 10:17 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		156,406,261		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		12,210,248				2.00
3.00	Total (sum of line 1 and line 2)		168,616,509		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		168,616,509		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		168,616,509		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: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/16/2017 10:17 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,982,171		6,982,171	1.00
2.00	SUBPROVIDER - IPF	3,793,506		3,793,506	2.00
3.00	SUBPROVIDER - IRF	0		0	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)	10,775,677		10,775,677	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,690,903		11,690,903	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)	11,690,903		11,690,903	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,466,580		22,466,580	17.00
18.00	Ancillary services	49,644,490	165,881,347	215,525,837	18.00
19.00	Outpatient services	4,473,395	46,788,388	51,261,783	19.00
20.00	RURAL HEALTH CLINIC	0	398,980	398,980	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	891,208	1,732,089	2,623,297	26.00
27.00	PRIVATE DUTY/DIETARY	0	443,828	443,828	27.00
27.01	SELF INSURED CHARGES	908,156	2,856,254	3,764,410	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	78,383,829	218,100,886	296,484,715	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		106,837,904		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		106,837,904		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/16/2017 10:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	296,484,715	1.00
2.00	Less contractual allowances and discounts on patients' accounts	193,000,144	2.00
3.00	Net patient revenues (line 1 minus line 2)	103,484,571	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	106,837,904	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,353,333	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	9,796,495	24.00
24.01	NON OPERATING INCOME	5,754,011	24.01
25.00	Total other income (sum of lines 6-24)	15,550,506	25.00
26.00	Total (line 5 plus line 25)	12,197,173	26.00
27.00	GAIN/LOSS INVENTORY ASSETS	-13,075	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-13,075	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,210,248	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O | Date/Time Prepared: 5/16/2017 10:17 am

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		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	303,331	165,101	468,432	0	468,432	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	595,571	595,571	0	595,571	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	5,998	5,998	0	5,998	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	124,628	124,628	0	124,628	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	3,827	3,827	0	3,827	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	874,688	0	874,688	0	874,688	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	163	0	163	0	163	34.00
35.00	DIETARY COUNSELING**	59	0	59	0	59	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	252	0	252	0	252	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	1,178,493	895,125	2,073,618	0	2,073,618	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O | Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	-86,502	381,930		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	595,571		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	5,998		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	124,628		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	3,827		15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	874,688		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0		33.00
34.00	SPIRITUAL COUNSELING**	0	163		34.00
35.00	DIETARY COUNSELING**	0	59		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	252		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-86,502	1,987,116		100.00

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

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-2 | Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	783,736	0	783,736	0	783,736	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	146	0	146	0	146	34.00
35.00	DIETARY COUNSELING	53	0	53	0	53	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	226	0	226	0	226	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	784,161	0	784,161	0	784,161	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	783,736		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	146		34.00
35.00	DIETARY COUNSELING	0	53		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	226		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	784,161		100.00

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

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

Provider CCN: 15-0037 Hospice CCN: 15-1547 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-3 | Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	39,606	0	39,606	0	39,606	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	7	0	7	0	7	34.00
35.00	DIETARY COUNSELING	3	0	3	0	3	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	11	0	11	0	11	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	39,627	0	39,627	0	39,627	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	39,606		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	7		34.00
35.00	DIETARY COUNSELING	0	3		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	11		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	39,627		100.00

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

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

Provider CCN: 15-0037 Hospice CCN: 15-1547 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-4 | Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	51,346	0	51,346	0	51,346	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	10	0	10	0	10	34.00
35.00	DIETARY COUNSELING	3	0	3	0	3	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	15	0	15	0	15	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	51,374	0	51,374	0	51,374	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	51,346		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	10		34.00
35.00	DIETARY COUNSELING	0	3		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	15		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	51,374		100.00

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

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

Provider CCN: 15-0037 Hospice CCN: 15-1547

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

Worksheet O-5

Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	294,517	294,517	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	181,273	181,273	3.00
4.00	ADMINISTRATIVE & GENERAL	381,930	534,405	916,335	4.00
5.00	PLANT OPERATION & MAINTENANCE	595,571	268,798	864,369	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	5,998	79,121	85,119	8.00
9.00	NURSING ADMINISTRATION	0	94,847	94,847	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	2,038	2,038	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	124,628	0	124,628	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	3,827		3,827	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	784,161		784,161	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	39,627		39,627	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	51,374		51,374	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	1,987,116	1,454,999	3,442,115	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6 Part I
Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	294,517	294,517				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	181,273	0	0	181,273		3.00
4.00	ADMINISTRATIVE & GENERAL	916,335	0	0	0	916,335	4.00
5.00	PLANT OPERATION & MAINTENANCE	864,369	0	0	0	864,369	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	85,119	0	0	0	85,119	8.00
9.00	NURSING ADMINISTRATION	94,847	0	0	0	94,847	9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,038	0	0	0	2,038	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	124,628	0	0	0	124,628	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	3,827	0	0	0	3,827	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	784,161			163,558	947,719	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	39,627	125,231	0	7,533	172,391	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	51,374	169,286	0	10,182	230,842	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	3,442,115	294,517	0	181,273	3,442,115	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0037 Hospice CCN: 15-1547 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-6 Part I Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	916,335					4.00
5.00	PLANT OPERATION & MAINTENANCE	313,587	1,177,956				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	30,881	0		0	116,000	8.00
9.00	NURSING ADMINISTRATION	34,410	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	739	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	45,214	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	1,388	0		0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	343,826					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	62,542	500,876	0	0	49,324	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	83,748	677,080	0	0	66,676	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	916,335	1,177,956	0	0	116,000	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6 Part I
Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	129,257					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	2,777				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	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 (DELETED)	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	116,625	2,506	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5,371	115	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	7,261	156	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	129,257	2,777	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6 Part I
Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (DELETED)	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	169,842					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	5,215				15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	153,244	4,705	0		1,568,625	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7,058	217	0	0	797,894	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	9,540	293	0	0	1,075,596	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	169,842	5,215	0	0	3,442,115	100.00

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

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6
Part II
Date/Time Prepared:
5/16/2017 10:17 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	722					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,388			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-916,335	2,525,780	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	864,369	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	85,119	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	94,847	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	2,038	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	124,628	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	3,827	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			6,666	0	947,719	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	307	0	307	0	172,391	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	415	0	415	0	230,842	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	294,517	0	181,273		916,335	100.00
101.00	UNIT COST MULTIPLIER	407.918283	0.000000	24.536140		0.362793	101.00

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

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6
Part II
Date/Time Prepared:
5/16/2017 10:17 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	722					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	722		8.00
9.00	NURSING ADMINISTRATION	0		0		7,388	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 (DELETED)	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					6,666	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	307	0	0	307	307	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	415	0	0	415	415	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	1,177,956	0	0	116,000	129,257	100.00
101.00	UNIT COST MULTIPLIER	1,631.518006	0.000000	0.000000	160.664820	17.495533	101.00

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

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6 Part II
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Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	7,388					10.00
11.00	MEDICAL RECORDS		7,388				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	7,388	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	6,666	6,666	0	0	6,666	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	307	307	0	0	307	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	415	415	0	0	415	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	2,777	0	0	0	169,842	100.00
101.00	UNIT COST MULTIPLIER	0.375880	0.000000	0.000000	0.000000	22.988901	101.00

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

Provider CCN: 15-0037
Hospice CCN: 15-1547

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (DELETED) (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	7,388				15.00
16.00	OTHER GENERAL SERVICE (DELETED)		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			722		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	6,666	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	307	0	307		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	415	0	415		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	5,215	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.705874	0.000000	0.000000		101.00

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

Provider CCN: 15-0037 Hospice CCN: 15-1547

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

Worksheet O-7

Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.413161	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.352343	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.433587	0	0	0	3.00
3.01	OCCUPATIONAL HEALTH	68.01	0.000000	0	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.222764	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.151479	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.814665	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	CARDIAC	76.00	0.000000	0	0	0	10.00
10.01	CARDIOPULMONARY	76.01	0.611573	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
3.01	OCCUPATIONAL HEALTH	0	0	0	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	CARDIAC	0	0	0	0	0	10.00
10.01	CARDIOPULMONARY	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-8 | Date/Time Prepared: 5/16/2017 10:17 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,568,625	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			6,666	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			235.32	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	6,075	71		9.00
10.00	Program cost (line 8 times line 9)	1,429,569	16,708		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			797,894	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			307	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			2,599.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	307	0		14.00
15.00	Program cost (line 13 times line 14)	797,893	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			1,075,596	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			415	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			2,591.80	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	398	0		19.00
20.00	Program cost (line 18 times line 19)	1,031,536	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,442,115	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			7,388	22.00
23.00	Average cost per diem (line 21 divided by line 22)			465.91	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0037	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/16/2017 10:17 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	732,940	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,633	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)	25.16	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)	734,573	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/16/2017 10:17 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	40,685	0	40,685	0	40,685	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	25,900	0	25,900	0	25,900	9.00
10.00	Subtotal (sum of lines 1 through 9)	66,585	0	66,585	0	66,585	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	66,585	0	66,585	0	66,585	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	36,873	245,852	282,725	0	282,725	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	36,873	245,852	282,725	0	282,725	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	103,458	245,852	349,310	0	349,310	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/16/2017 10:17 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	40,685		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	25,900		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	66,585		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	66,585		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-11,464	271,261		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-11,464	271,261		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-11,464	337,846		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-2 | Date/Time Prepared: 5/16/2017 10:17 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	RHC I Greater of col. 2 or col. 4	Cost	
		1.00	2.00	3.00	4.00	5.00		
	VISITS AND PRODUCTIVITY							
	Positions							
1.00	Physician	0.00	0	0	0			1.00
2.00	Physician Assistant	0.00	0	0	0			2.00
3.00	Nurse Practitioner	0.78	2,159	2,100	1,638			3.00
4.00	Subtotal (sum of lines 1 through 3)	0.78	2,159		1,638	2,159		4.00
5.00	Visiting Nurse	0.00	0			0		5.00
6.00	Clinical Psychologist	0.00	0			0		6.00
7.00	Clinical Social Worker	0.00	0			0		7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0		7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0		7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.78	2,159			2,159		8.00
9.00	Physician Services Under Agreements		0			0		9.00
						1.00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					66,585		10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0		11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					66,585		12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000		13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					271,261		14.00
15.00	Parent provider overhead allocated to facility (see instructions)					90,832		15.00
16.00	Total overhead (sum of lines 14 and 15)					362,093		16.00
17.00	Allowable GME overhead (see instructions)					0		17.00
18.00	Enter the amount from line 16					362,093		18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					362,093		19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					428,678		20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2016 To 12/31/2016	Worksheet M-3 Date/Time Prepared: 5/16/2017 10:17 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		428,678	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		18,226	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		410,452	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,159	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,159	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		190.11	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	80.44	81.32	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	94	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	7,644	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	7,644	16.00
16.01	Total program charges (see instructions)(from contractor's records)		20,849	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		2,634	16.04
16.05	Total program cost (see instructions)	0	2,634	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,351	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,300	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		2,634	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,604	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		9,238	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		9,238	26.00
26.01	Sequestration adjustment (see instructions)		185	26.01
27.00	Interim payments		2,147	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		6,906	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2016 To 12/31/2016	Worksheet M-4 Date/Time Prepared: 5/16/2017 10:17 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	66,585	66,585	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000265	0.010000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	18	666	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	237	1,910	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	255	2,576	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	66,585	66,585	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	362,093	362,093	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003830	0.038687	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,387	14,008	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,642	16,584	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	3	113	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	547.33	146.76	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	45	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	6,604	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		18,226	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		6,604	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2016 To 12/31/2016	Worksheet M-5 Date/Time Prepared: 5/16/2017 10:17 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		2,147	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,147	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		6,906	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		9,053	7.00

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