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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 1/20/2020 10:18 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/20/2020 Time: 10:18 am
2. [ ] Manually submitted cost report
3. [1] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOOD SAMARITAN HOSPITAL (15-0042) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-2,841	193,607	0	-325,807	1.00
2.00	Subprovider - IPF	0	7,056	-9		44,196	2.00
3.00	Subprovider - IRF	0	20,181	15		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	24,396	193,613	0	-281,611	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/20/2020 10:18 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 520 SOUTH 7TH STREET	PO Box:			1.00
2.00	City: VINCENNES	State: IN	Zip Code: 47591	County: KNOX	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GOOD SAMARITAN HOSPITAL	150042	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	GOOD SAMARITAN HOSPITAL	15S042	99915	4	01/01/1984	N	P	O	4.00
5.00	Subprovider - IRF	GOOD SAMARITAN - REHAB	15T042	99915	5	01/01/2001	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GOOD SAMARITAN HOME CENTER	157432	99915		06/27/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	GOOD SAMARITAN LINCOLN TRAIL HOSPICE	151526	99915		01/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	9		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	276	1,012	0	344	1,196	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/20/2020 10:18 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	89	0	0	49		25.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 1/20/2020 10:18 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 1/20/2020 10:18 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 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	443,199	5,494	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/20/2020 10:18 am

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	12/31/2018	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/20/2020 10:18 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 1/20/2020 10:18 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.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/21/2019	N	03/21/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 1/20/2020 10:18 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				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO, LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 1/20/2020 10:18 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.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 1/20/2020 10:18 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	69	25,185	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)		69	25,185	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,950	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		99	36,135	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,125		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		144				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 1/20/2020 10:18 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)	8,314	232	12,998			1.00
2.00	HMO and other (see instructions)	1,757	2,517				2.00
3.00	HMO IPF Subprovider	91	0				3.00
4.00	HMO IRF Subprovider	270	138				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)	8,314	232	12,998			7.00
8.00	INTENSIVE CARE UNIT	4,530	0	7,149			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		43	995			13.00
14.00	Total (see instructions)	12,844	275	21,142	0.00	1,253.58	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,645	179	4,410	0.00	31.89	16.00
17.00	SUBPROVIDER - IRF	6,323	0	7,324	0.00	35.75	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	9.86	24.00
24.10	HOSPICE (non-distinct part)			681			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,331.08	27.00
28.00	Observation Bed Days		811	4,160			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	36	98			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 1/20/2020 10:18 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	3,160	66	5,385	1.00
2.00	HMO and other (see instructions)			338	619		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				11		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	3,160	66	5,385	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	194	37	824	16.00
17.00	SUBPROVIDER - IRF	0.00	0	486	0	556	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 1/20/2020 10:18 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	103,922,123	0	103,922,123	3,356,846.00	30.96	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		19,721	0	19,721	120.00	164.34	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		4,243,413	0	4,243,413	22,830.00	185.87	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		35,800,677	0	35,800,677	866,965.00	41.29	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		237,056	0	237,056	3,450.00	68.71	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		519,470	0	519,470	4,948.00	104.99	13.00
14.00	Home office and/or related organization 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)		19,619,894	0	19,619,894			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		8,078,488	0	8,078,488			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		2,071	0	2,071			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		417,953	0	417,953			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II | Date/Time Prepared: 1/20/2020 10:18 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	5,307,818	0	5,307,818	292,955.00	18.12	26.00
27.00	Administrative & General	5.00	9,068,076	0	9,068,076	269,469.00	33.65	27.00
28.00	Administrative & General under contract (see inst.)		224,803	0	224,803	1,431.00	157.10	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,180,898	0	2,180,898	95,597.00	22.81	30.00
31.00	Laundry & Linen Service	8.00	206,759	0	206,759	15,790.00	13.09	31.00
32.00	Housekeeping	9.00	1,994,584	0	1,994,584	138,570.00	14.39	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,639,560	-1,209,046	430,514	27,890.00	15.44	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,209,046	1,209,046	78,326.00	15.44	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,428,144	0	1,428,144	32,033.00	44.58	38.00
39.00	Central Services and Supply	14.00	367,321	0	367,321	23,029.00	15.95	39.00
40.00	Pharmacy	15.00	2,883,987	0	2,883,987	71,616.00	40.27	40.00
41.00	Medical Records & Medical Records Library	16.00	2,436,861	0	2,436,861	104,191.00	23.39	41.00
42.00	Social Service	17.00	717,946	0	717,946	26,662.00	26.93	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 1/20/2020 10:18 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)		99,903,513	0	99,903,513	3,335,447.00	29.95	1.00
2.00	Excluded area salaries (see instructions)		35,800,677	0	35,800,677	866,965.00	41.29	2.00
3.00	Subtotal salaries (line 1 minus line 2)		64,102,836	0	64,102,836	2,468,482.00	25.97	3.00
4.00	Subtotal other wages & related costs (see inst.)		756,526	0	756,526	8,398.00	90.08	4.00
5.00	Subtotal wage-related costs (see inst.)		19,621,965	0	19,621,965	0.00	30.61	5.00
6.00	Total (sum of lines 3 thru 5)		84,481,327	0	84,481,327	2,476,880.00	34.11	6.00
7.00	Total overhead cost (see instructions)		28,456,757	0	28,456,757	1,177,559.00	24.17	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 1/20/2020 10:18 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)	4,566,143	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	15,547,599	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	327,875	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	147,120	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)	342,607	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	6,799,320	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	33,159	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	47,026	22.00
23.00	Tuition Reimbursement	307,557	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	28,118,406	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V | Date/Time Prepared: 1/20/2020 10:18 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	237,056	28,118,406	1.00
2.00	Hospital	237,056	28,118,406	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

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

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

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 1/20/2020 10:18 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	6,873	124	932	7,929	11.00
12.00	Hospice Inpatient Respite Care	32	7	24	63	12.00
13.00	Hospice General Inpatient Care	514	15	93	622	13.00
14.00	Total Hospice Days	7,419	146	1,049	8,614	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 1/20/2020 10:18 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)	0.244668	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	29,608,637	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	185,953,717	6.00
7.00	Medicaid cost (line 1 times line 6)	45,496,924	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)	15,888,287	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	15,888,287	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	9,744,164	1,554,659	11,298,823	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,384,085	1,554,659	3,938,744	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,384,085	1,554,659	3,938,744	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	19,998,906	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	619,686	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	953,362	27.01
28.00	Non-Medicare bad debt expense (see instructions)	19,045,544	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	4,993,511	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	8,932,255	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	24,820,542	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 1/20/2020 10:18 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	CAP REL COSTS-BLDG & FIXT		20,183,499	20,183,499	6,157,401	26,340,900	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		21,758	21,758	0	21,758	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	644,952	2,094,650	2,739,602	26,550,652	29,290,254	4.00
4.01	00401	COMMUNICATIONS	280,900	75,476	356,376	-74,638	281,738	4.01
4.02	00402	PURCHASING & RECEIVING	694,499	602,549	1,297,048	-298,387	998,661	4.02
4.03	00403	REGISTRATION	1,253,808	422,561	1,676,369	-392,575	1,283,794	4.03
4.04	00404	PATIENT ACCOUNTS	2,433,659	2,233,538	4,667,197	-788,866	3,878,331	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	9,068,076	22,249,155	31,317,231	-2,654,460	28,662,771	5.00
7.00	00700	OPERATION OF PLANT	2,180,898	4,359,468	6,540,366	-646,133	5,894,233	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	206,759	186,651	393,410	-92,757	300,653	8.00
9.00	00900	HOUSEKEEPING	1,994,584	997,306	2,991,890	-769,943	2,221,947	9.00
10.00	01000	DIETARY	1,639,560	2,039,454	3,679,014	-2,855,961	823,053	10.00
11.00	01100	CAFETERIA	0	0	0	2,311,446	2,311,446	11.00
13.00	01300	NURSING ADMINISTRATION	1,428,144	516,796	1,944,940	-340,986	1,603,954	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	367,321	306,186	673,507	-137,018	536,489	14.00
15.00	01500	PHARMACY	2,883,987	16,932,211	19,816,198	-16,605,302	3,210,896	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,436,861	1,198,210	3,635,071	-766,178	2,868,893	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	717,946	425,023	1,142,969	-197,522	945,447	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	222,786	65,919	288,705	-60,231	228,474	23.00
23.01	02301	PARAMED ED PRGM-LAB	214,465	32,859	247,324	-50,949	196,375	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,414,604	1,616,150	6,030,754	-1,169,156	4,861,598	30.00
31.00	03100	INTENSIVE CARE UNIT	3,547,217	1,390,388	4,937,605	-990,785	3,946,820	31.00
40.00	04000	SUBPROVIDER - IPF	1,850,794	597,532	2,448,326	-435,942	2,012,384	40.00
41.00	04100	SUBPROVIDER - IRF	1,732,693	603,584	2,336,277	-515,834	1,820,443	41.00
43.00	04300	NURSERY	297,324	99,728	397,052	-79,160	317,892	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,516,189	5,647,598	9,163,787	-4,483,960	4,679,827	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,005,330	1,092,933	2,098,263	-533,227	1,565,036	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,191,158	414,737	1,605,895	-301,011	1,304,884	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,829,231	3,631,502	7,460,733	-1,857,707	5,603,026	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,610,961	1,578,917	4,189,878	-650,455	3,539,423	55.00
60.00	06000	LABORATORY	2,276,662	4,915,097	7,191,759	-640,660	6,551,099	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,150,183	1,776,258	3,926,441	-843,315	3,083,126	65.00
66.00	06600	PHYSICAL THERAPY	3,804,055	1,158,145	4,962,200	-1,027,280	3,934,920	66.00
69.00	06900	ELECTROCARDIOLOGY	4,863,753	3,229,099	8,092,852	-2,501,640	5,591,212	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	402,980	321,410	724,390	-99,088	625,302	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,241,917	7,241,917	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,349,837	5,349,837	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,898,700	15,898,700	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,198,091	2,342,199	3,540,290	-1,649,670	1,890,620	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	548,854	548,854	-5,362	543,492	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	108,848	37,012	145,860	-30,300	115,560	90.00
90.01	04950	WOUND CLINIC	400,108	2,725,135	3,125,243	-1,878,650	1,246,593	90.01
91.00	09100	EMERGENCY	4,181,575	1,708,743	5,890,318	-1,194,036	4,696,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	91,223	99,297	190,520	-62,350	128,170	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		5,876,718	5,876,718	-5,876,718	0	113.00
116.00	11600	HOSPICE	531,026	682,711	1,213,737	-156,841	1,056,896	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,673,210	117,037,016	189,710,226	9,794,900	199,505,126	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,628,847	21,845,341	47,474,188	-8,254,367	39,219,821	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	16,229	16,229	0	16,229	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	168,477	463,480	631,957	-44,043	587,914	194.02
194.03	07953	MH RESIDENTIAL	375,014	132,795	507,809	-89,491	418,318	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	36,956	36,956	0	36,956	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 1/20/2020 10:18 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	
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	5,076,575	1,884,360	6,960,935	-1,406,999	5,553,936	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	103,922,123	141,416,177	245,338,300	0	245,338,300	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,188,554	25,152,346		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	21,758		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-30,425	29,259,829		4.00
4.01	00401	COMMUNICATIONS	0	281,738		4.01
4.02	00402	PURCHASING & RECEIVING	-268,518	730,143		4.02
4.03	00403	REGISTRATION	0	1,283,794		4.03
4.04	00404	PATIENT ACCOUNTS	-193,387	3,684,944		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-11,012,243	17,650,528		5.00
7.00	00700	OPERATION OF PLANT	-22,097	5,872,136		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-11,571	289,082		8.00
9.00	00900	HOUSEKEEPING	-238,795	1,983,152		9.00
10.00	01000	DIETARY	0	823,053		10.00
11.00	01100	CAFETERIA	-1,095,804	1,215,642		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,603,954		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	536,489		14.00
15.00	01500	PHARMACY	-14,953	3,195,943		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-96,379	2,772,514		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
17.01	01701	MENTAL HEALTH OH	-114,639	830,808		17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	-53,861	174,613		23.00
23.01	02301	PARAMED ED PRGM-LAB	0	196,375		23.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,861,598		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,946,820		31.00
40.00	04000	SUBPROVIDER - IPF	-317,123	1,695,261		40.00
41.00	04100	SUBPROVIDER - IRF	-90,812	1,729,631		41.00
43.00	04300	NURSERY	0	317,892		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,339,219	3,340,608		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	-12,000	1,553,036		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,304,884		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20,927	5,582,099		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,402,941	2,136,482		55.00
60.00	06000	LABORATORY	-36,212	6,514,887		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	-911,964	2,171,162		65.00
66.00	06600	PHYSICAL THERAPY	-7,656	3,927,264		66.00
69.00	06900	ELECTROCARDIOLOGY	-2,717,564	2,873,648		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	-11,289	614,013		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,100	7,240,817		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,349,837		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-385,851	15,512,849		73.00
75.00	07500	ASC (NON-DISTINCT PART)	-60,390	1,830,230		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	-199,297	344,195		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	115,560		90.00
90.01	04950	WOUND CLINIC	-1,146	1,245,447		90.01
91.00	09100	EMERGENCY	-83,798	4,612,484		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	128,170		96.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	-66	1,056,830		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-21,940,581	177,564,545		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39,219,821		192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	16,229		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	587,914		194.02
194.03	07953	MH RESIDENTIAL	0	418,318		194.03
194.04	07954	UNUSED SPACE	0	0		194.04
194.05	07955	MOB	0	36,956		194.05
194.06	07956	FOUNDATION	0	0		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0		194.07

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.08	07958	INDUSTRIAL HEALTH	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	5,553,936		194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-21,940,581	223,397,719		200.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/20/2020 10:18 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,898,700		1.00
	TOTALS		0	15,898,700		
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,241,917		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,349,837		2.00
3.00	LABORATORY	60.00	0	37,917		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
	TOTALS		0	12,629,671		
	C - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26,594,691		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/20/2020 10:18 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
	TOTALS		0	26,594,691		
	D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,836,167		1.00
2.00	PATIENT ACCOUNTS	4.04	0	40,551		2.00
	TOTALS		0	5,876,718		
	E - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	321,234		1.00
	TOTALS		0	321,234		
	F - DIETARY RECLASS					
1.00	CAFETERIA	11.00	1,209,046	1,102,400		1.00
	TOTALS		1,209,046	1,102,400		
500.00	Grand Total: Increases		1,209,046	62,423,414		500.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/20/2020 10:18 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	15,898,700	0		1.00
	TOTALS		0	15,898,700			
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44,039	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	10	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	11,333	0		3.00
4.00	OPERATION OF PLANT	7.00	0	1,319	0		4.00
5.00	HOUSEKEEPING	9.00	0	30	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	244	0		6.00
7.00	PHARMACY	15.00	0	9,155	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	39,720	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	64,706	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	1,337	0		10.00
11.00	SUBPROVIDER - IRF	41.00	0	8,993	0		11.00
12.00	NURSERY	43.00	0	8,578	0		12.00
13.00	OPERATING ROOM	50.00	0	3,565,073	0		13.00
14.00	ENDOSCOPY	51.01	0	276,701	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	14,866	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	839,481	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	10,855	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	198,365	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	28,684	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	1,518,535	0		20.00
21.00	NEURODIAGNOSTICS	70.01	0	2,716	0		21.00
22.00	ASC (NON-DISTINCT PART)	75.00	0	1,295,215	0		22.00
23.00	INPATIENT DIALYSIS	76.01	0	5,362	0		23.00
24.00	CLINIC	90.00	0	332	0		24.00
25.00	WOUND CLINIC	90.01	0	1,799,549	0		25.00
26.00	EMERGENCY	91.00	0	112,324	0		26.00
27.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	38,478	0		27.00
28.00	HOSPICE	116.00	0	4,091	0		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,727,961	0		29.00
30.00	MH RESIDENTIAL	194.03	0	312	0		30.00
31.00	COMMUNITY MENTAL HEALTH CENTER	194.09	0	1,307	0		31.00
	TOTALS		0	12,629,671			
	C - EMPLOYEE BENEFITS						
1.00	COMMUNICATIONS	4.01	0	74,638	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	298,377	0		2.00
3.00	REGISTRATION	4.03	0	392,575	0		3.00
4.00	PATIENT ACCOUNTS	4.04	0	829,417	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	2,321,893	0		5.00
6.00	OPERATION OF PLANT	7.00	0	644,814	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	92,757	0		7.00
8.00	HOUSEKEEPING	9.00	0	769,913	0		8.00
9.00	DIETARY	10.00	0	544,515	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	340,986	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	136,774	0		11.00
12.00	PHARMACY	15.00	0	697,447	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	766,178	0		13.00
14.00	MENTAL HEALTH OH	17.01	0	197,522	0		14.00
15.00	PARAMED ED PRGM-RADIOLOGY	23.00	0	60,231	0		15.00
16.00	PARAMED ED PRGM-LAB	23.01	0	50,949	0		16.00
17.00	ADULTS & PEDIATRICS	30.00	0	1,129,436	0		17.00
18.00	INTENSIVE CARE UNIT	31.00	0	926,079	0		18.00
19.00	SUBPROVIDER - IPF	40.00	0	434,605	0		19.00
20.00	SUBPROVIDER - IRF	41.00	0	506,841	0		20.00
21.00	NURSERY	43.00	0	70,582	0		21.00
22.00	OPERATING ROOM	50.00	0	918,887	0		22.00
23.00	ENDOSCOPY	51.01	0	256,526	0		23.00
24.00	DELIVERY ROOM & LABOR ROOM	52.00	0	286,145	0		24.00
25.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,018,226	0		25.00
26.00	RADIOLOGY-THERAPEUTIC	55.00	0	639,600	0		26.00
27.00	LABORATORY	60.00	0	678,577	0		27.00
28.00	RESPIRATORY THERAPY	65.00	0	644,950	0		28.00
29.00	PHYSICAL THERAPY	66.00	0	998,596	0		29.00
30.00	ELECTROCARDIOLOGY	69.00	0	983,105	0		30.00
31.00	NEURODIAGNOSTICS	70.01	0	96,372	0		31.00
32.00	ASC (NON-DISTINCT PART)	75.00	0	354,455	0		32.00
33.00	CLINIC	90.00	0	29,968	0		33.00
34.00	WOUND CLINIC	90.01	0	79,101	0		34.00
35.00	EMERGENCY	91.00	0	1,081,712	0		35.00
36.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	23,872	0		36.00

RECLASSIFICATIONS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/20/2020 10:18 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
37.00	HOSPICE	116.00	0	152,750	0		37.00
38.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,526,406	0		38.00
39.00	MARKETING AND PUBLIC RELATIONS	194.02	0	44,043	0		39.00
40.00	MH RESIDENTIAL	194.03	0	89,179	0		40.00
41.00	COMMUNITY MENTAL HEALTH CENTER	194.09	0	1,405,692	0		41.00
	TOTALS		0	26,594,691			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	5,876,718	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	5,876,718			
	E - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	321,234	12		1.00
	TOTALS		0	321,234			
	F - DIETARY RECLASS						
1.00	DIETARY	10.00	1,209,046	1,102,400	0		1.00
	TOTALS		1,209,046	1,102,400			
500.00	Grand Total: Decreases		1,209,046	62,423,414			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I Date/Time Prepared: 1/20/2020 10:18 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	6,912,648	0	0	0	131,200	1.00
2.00	Land Improvements	10,608,071	72,355	0	72,355	3,498	2.00
3.00	Buildings and Fixtures	160,623,658	414,151	0	414,151	0	3.00
4.00	Building Improvements	837,218	25,732	0	25,732	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	215,638,087	7,030,599	0	7,030,599	5,462,533	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	394,619,682	7,542,837	0	7,542,837	5,597,231	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	394,619,682	7,542,837	0	7,542,837	5,597,231	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	6,781,448	0	1.00
2.00	Land Improvements	10,676,928	0	2.00
3.00	Buildings and Fixtures	161,037,809	0	3.00
4.00	Building Improvements	862,950	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	217,206,153	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	396,565,288	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	396,565,288	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 1/20/2020 10:18 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	CAP REL COSTS-BLDG & FIXT	20,183,499	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	21,758	0	0	2.00
3.00	Total (sum of lines 1-2)	20,183,499	0	21,758	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	20,183,499	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	21,758	2.00
3.00	Total (sum of lines 1-2)	0	20,205,257	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III | Date/Time Prepared: 1/20/2020 10:18 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	CAP REL COSTS-BLDG & FIXT	179,359,135	0	179,359,135	0.452281	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	217,206,153	0	217,206,153	0.547719	0	2.00
3.00	Total (sum of lines 1-2)	396,565,288	0	396,565,288	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	20,183,499	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,183,499	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	4,647,613	321,234	0	0	25,152,346	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,758	0	0	0	21,758	2.00
3.00	Total (sum of lines 1-2)	4,669,371	321,234	0	0	25,174,104	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/20/2020 10:18 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-86,876	PURCHASING & RECEIVING	4.02	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-21,801	OPERATION OF PLANT	7.00	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	-7,085,183			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-473,141	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-385,851	DRUGS CHARGED TO PATIENTS	73.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/20/2020 10:18 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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-664,104	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	RENTAL	B	-870	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISC INCOME	B	-181,642	PURCHASING & RECEIVING	4.02	0	33.02
33.03	MISC INCOME	B	-6,576	PATIENT ACCOUNTS	4.04	0	33.03
33.04	MISC INCOME	B	-296	OPERATION OF PLANT	7.00	0	33.04
33.05	MISC INCOME	B	-11,571	LAUNDRY & LINEN SERVICE	8.00	0	33.05
33.06	MISC INCOME	B	-238,795	HOUSEKEEPING	9.00	0	33.06
33.07	MISC INCOME	B	-3,023	PHARMACY	15.00	0	33.07
33.08	MISC INCOME	B	-96,379	MEDICAL RECORDS & LIBRARY	16.00	0	33.08
33.09	MISC INCOME	B	-30,069	MENTAL HEALTH OH	17.01	0	33.09
33.10	MISC INCOME	B	-53,861	PARAMED ED PRGM-RADIOLOGY	23.00	0	33.10
33.11	MISC INCOME	B	-32,697	SUBPROVIDER - IRF	41.00	0	33.11
33.12	MISC INCOME	B	-9,577	OPERATING ROOM	50.00	0	33.12
33.13	MISC INCOME	B	-12,000	ENDOSCOPY	51.01	0	33.13
33.14	MISC INCOME	B	-7,656	PHYSICAL THERAPY	66.00	0	33.14
33.15	MISC INCOME	B	-45,064	ELECTROCARDIOLOGY	69.00	0	33.15
33.16	MISC INCOME	B	-1,100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.16
33.17	MISC INCOME	B	-3,014	ASC (NON-DISTINCT PART)	75.00	0	33.17
33.18	MISC INCOME	B	-1,146	WOUND CLINIC	90.01	0	33.18
33.19	MISC INCOME	B	-51	ELECTROCARDIOLOGY	69.00	0	33.19
33.20	GME SALARY REIMBURSEMENT	B	-91,267	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	OTHER MISC FEES	B	-622,663	CAFETERIA	11.00	0	33.21
33.22	PROVIDER ASSESSMENT FEE	A	-9,774,644	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	GME CONSORTIUM FEES	A	-250,000	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	INTEREST INCOME	B	-1,188,554	CAP REL COSTS-BLDG & FIXT	1.00	11	33.24
33.25	PHYSICIAN BILLING COSTS	A	-186,811	PATIENT ACCOUNTS	4.04	0	33.25
33.26	DONATIONS EXPENSE	A	-84,226	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	ADVERTISING	A	-12,272	MENTAL HEALTH OH	17.01	0	33.27
33.28	ADVERTISING	A	-3,115	SUBPROVIDER - IRF	41.00	0	33.28
33.29	ADVERTISING	A	-527	RADIOLOGY-DIAGNOSTIC	54.00	0	33.29
33.30	ADVERTISING	A	-4,288	ELECTROCARDIOLOGY	69.00	0	33.30
33.31	ADVERTISING	A	-66	HOSPICE	116.00	0	33.31
33.32	2012 BOND ISSUE COSTS	A	45,855	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	AHA LOBBYING OFFSET	A	-8,389	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	IHA LOBBYING OFFSET	A	-5,513	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	INDIANA CHAMBER LOBBYING OFFSET	A	-150	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	IHRA LOBBYING OFFSET	A	-5,000	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	RENTAL	B	-22,890	OPERATING ROOM	50.00	0	33.37
33.38	RENTAL	B	-1,050	ELECTROCARDIOLOGY	69.00	0	33.38
33.39	RENTAL	B	-193,462	INPATIENT DIALYSIS	76.01	0	33.39
33.40	MISC INCOME	B	-72,199	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	MISC INCOME	B	-157	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	OTHER REVENUE	B	-600	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	RENTAL	B	-6,250	ADMINISTRATIVE & GENERAL	5.00	0	33.43
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,940,581				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 1/20/2020 10:18 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	29,555	29,555	0	211,500	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	240,432	95,599	144,833	211,500	1,519	2.00
3.00	13.00	NURSING ADMINISTRATION	11,000	0	11,000	211,500	113	3.00
4.00	15.00	PHARMACY	21,930	11,930	10,000	211,500	105	4.00
5.00	17.01	MENTAL HEALTH OH	84,500	46,000	38,500	211,500	120	5.00
6.00	40.00	SUBPROVIDER - IPF	317,123	317,123	0	181,300	0	6.00
7.00	41.00	SUBPROVIDER - IRF	55,000	55,000	0	211,500	0	7.00
8.00	50.00	OPERATING ROOM	1,306,752	1,306,752	0	246,400	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	20,400	20,400	0	271,900	0	9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	1,421,447	1,387,007	34,440	211,500	182	10.00
11.00	60.00	LABORATORY	131,976	36,212	95,764	211,500	1,775	11.00
12.00	65.00	RESPIRATORY THERAPY	929,964	911,964	18,000	211,500	300	12.00
13.00	69.00	ELECTROCARDIOLOGY	2,690,701	2,630,192	60,509	211,500	232	13.00
14.00	70.01	NEURODIAGNOSTICS	18,000	0	18,000	211,500	66	14.00
15.00	75.00	ASC (NON-DISTINCT PART)	87,881	54,210	33,671	211,500	300	15.00
16.00	76.01	INPATIENT DIALYSIS	40,000	0	40,000	211,500	336	16.00
17.00	90.01	WOUND CLINIC	0	0	0	211,500	0	17.00
18.00	91.00	EMERGENCY	96,000	60,000	36,000	211,500	120	18.00
200.00			7,502,661	6,961,944	540,717		5,168	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	154,456	7,723	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	11,490	575	0	0	0	3.00
4.00	15.00	PHARMACY	10,677	534	0	0	0	4.00
5.00	17.01	MENTAL HEALTH OH	12,202	610	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	18,506	925	0	0	0	10.00
11.00	60.00	LABORATORY	180,487	9,024	0	0	0	11.00
12.00	65.00	RESPIRATORY THERAPY	30,505	1,525	0	0	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	23,590	1,180	0	0	0	13.00
14.00	70.01	NEURODIAGNOSTICS	6,711	336	0	0	0	14.00
15.00	75.00	ASC (NON-DISTINCT PART)	30,505	1,525	0	0	0	15.00
16.00	76.01	INPATIENT DIALYSIS	34,165	1,708	0	0	0	16.00
17.00	90.01	WOUND CLINIC	0	0	0	0	0	17.00
18.00	91.00	EMERGENCY	12,202	610	0	0	0	18.00
200.00			525,496	26,275	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	29,555		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	154,456	0	95,599		2.00
3.00	13.00	NURSING ADMINISTRATION	0	11,490	0	0		3.00
4.00	15.00	PHARMACY	0	10,677	0	11,930		4.00
5.00	17.01	MENTAL HEALTH OH	0	12,202	26,298	72,298		5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	317,123		6.00
7.00	41.00	SUBPROVIDER - IRF	0	0	0	55,000		7.00
8.00	50.00	OPERATING ROOM	0	0	0	1,306,752		8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	20,400		9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	0	18,506	15,934	1,402,941		10.00
11.00	60.00	LABORATORY	0	180,487	0	36,212		11.00
12.00	65.00	RESPIRATORY THERAPY	0	30,505	0	911,964		12.00
13.00	69.00	ELECTROCARDIOLOGY	0	23,590	36,919	2,667,111		13.00
14.00	70.01	NEURODIAGNOSTICS	0	6,711	11,289	11,289		14.00
15.00	75.00	ASC (NON-DISTINCT PART)	0	30,505	3,166	57,376		15.00
16.00	76.01	INPATIENT DIALYSIS	0	34,165	5,835	5,835		16.00
17.00	90.01	WOUND CLINIC	0	0	0	0		17.00
18.00	91.00	EMERGENCY	0	12,202	23,798	83,798		18.00
200.00			0	525,496	123,239	7,085,183		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	25,152,346	25,152,346				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	21,758		21,758			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	29,259,829	131,810	110	29,391,749		4.00
4.01	00401	COMMUNICATIONS	281,738	0	0	79,942	361,680	4.01
4.02	00402	PURCHASING & RECEIVING	730,143	455,619	379	197,648	2,910	4.02
4.03	00403	REGISTRATION	1,283,794	0	0	356,822	5,174	4.03
4.04	00404	PATIENT ACCOUNTS	3,684,944	0	0	692,597	6,952	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	17,650,528	1,236,249	1,145	2,580,693	24,737	5.00
7.00	00700	OPERATION OF PLANT	5,872,136	3,832,674	3,451	620,664	23,444	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	289,082	154,385	132	58,842	0	8.00
9.00	00900	HOUSEKEEPING	1,983,152	215,071	184	567,641	5,982	9.00
10.00	01000	DIETARY	823,053	0	0	122,520	4,527	10.00
11.00	01100	CAFETERIA	1,215,642	367,023	314	344,084	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,603,954	251,835	215	406,437	3,234	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	536,489	2,639	2	104,536	1,455	14.00
15.00	01500	PHARMACY	3,195,943	181,444	155	820,757	5,174	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,772,514	138,289	118	693,509	8,407	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	830,808	100,910	86	204,321	35,570	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	174,613	0	0	63,403	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	196,375	0	0	61,035	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,861,598	2,047,721	1,751	1,256,357	23,767	30.00
31.00	03100	INTENSIVE CARE UNIT	3,946,820	783,855	670	1,009,506	15,360	31.00
40.00	04000	SUBPROVIDER - IPF	1,695,261	382,121	327	526,719	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,729,631	504,051	431	493,109	11,318	41.00
43.00	04300	NURSERY	317,892	0	0	84,616	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,340,608	554,242	474	1,000,676	23,929	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,553,036	358,755	307	286,108	4,204	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,304,884	0	0	338,993	14,875	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,582,099	967,410	827	1,089,765	10,671	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,136,482	225,655	193	743,056	5,982	55.00
60.00	06000	LABORATORY	6,514,887	212,198	182	647,918	5,174	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,171,162	166,493	142	611,923	6,306	65.00
66.00	06600	PHYSICAL THERAPY	3,927,264	646,738	553	1,082,600	5,335	66.00
69.00	06900	ELECTROCARDIOLOGY	2,873,648	533,017	456	1,384,180	12,611	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	614,013	224,130	192	114,684	3,234	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,240,817	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,349,837	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,512,849	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,830,230	0	0	340,966	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	344,195	251,601	215	0	485	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	115,560	78,218	67	30,977	1,455	90.00
90.01	04950	WOUND CLINIC	1,245,447	84,492	72	113,867	1,617	90.01
91.00	09100	EMERGENCY	4,612,484	508,449	435	1,190,039	16,330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	128,170	11,551	10	25,961	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,056,830	116,419	100	151,125	3,719	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	177,564,545	15,725,064	13,695	20,498,596	293,938	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,219,821	3,378,695	2,890	7,293,732	60,790	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	16,229	74,349	64	0	3,395	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	587,914	55,322	47	47,947	970	194.02
194.03	07953	MH RESIDENTIAL	418,318	593,967	508	106,726	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
194.04	07954	UNUSED SPACE	0	3,397,487	2,906	0	0	194.04
194.05	07955	MOB	36,956	701,972	600	0	0	194.05
194.06	07956	FOUNDATION	0	13,662	12	0	323	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	138,143	118	0	2,264	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	5,553,936	1,073,685	918	1,444,748	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	223,397,719	25,152,346	21,758	29,391,749	361,680	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING	1,386,699					4.02
4.03	00403	REGISTRATION	624	1,646,414				4.03
4.04	00404	PATIENT ACCOUNTS	952	0	4,385,445			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	4,624	0	0	21,497,976	21,497,976	5.00
7.00	00700	OPERATION OF PLANT	12,243	0	0	10,364,612	1,103,603	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,361	0	0	507,802	54,070	8.00
9.00	00900	HOUSEKEEPING	13,344	0	0	2,785,374	296,581	9.00
10.00	01000	DIETARY	96,029	0	0	1,046,129	111,390	10.00
11.00	01100	CAFETERIA	0	0	0	1,927,063	205,190	11.00
13.00	01300	NURSING ADMINISTRATION	523	0	0	2,266,198	241,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,353	0	0	651,474	69,368	14.00
15.00	01500	PHARMACY	4,399	0	0	4,207,872	448,046	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	441	0	0	3,613,278	384,735	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	50	0	0	1,171,745	124,765	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	10	0	0	238,026	25,345	23.00
23.01	02301	PARAMED ED PRGM-LAB	435	0	0	257,845	27,455	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,437	73,129	194,753	8,485,513	903,520	30.00
31.00	03100	INTENSIVE CARE UNIT	19,853	49,264	131,197	5,956,525	634,239	31.00
40.00	04000	SUBPROVIDER - IPF	1,888	19,886	52,960	2,679,162	285,272	40.00
41.00	04100	SUBPROVIDER - IRF	5,858	19,704	52,475	2,816,577	299,903	41.00
43.00	04300	NURSERY	1,172	3,587	9,553	416,820	44,382	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,885	139,347	371,102	5,464,263	581,824	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	30,209	29,262	77,928	2,339,809	249,138	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,677	16,348	43,537	1,724,314	183,602	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,378	234,210	624,543	8,519,903	907,182	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,371	56,669	150,917	3,324,325	353,967	55.00
60.00	06000	LABORATORY	181,266	168,400	448,473	8,178,498	870,830	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,200	41,555	110,666	3,113,447	331,514	65.00
66.00	06600	PHYSICAL THERAPY	1,849	63,027	167,849	5,895,215	627,711	66.00
69.00	06900	ELECTROCARDIOLOGY	5,833	116,104	309,202	5,235,051	557,418	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,021	13,884	36,974	1,009,132	107,450	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	310,290	10	28	7,551,145	804,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	359,387	0	0	5,709,224	607,907	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	173,340	461,629	16,147,818	1,719,387	73.00
75.00	07500	ASC (NON-DISTINCT PART)	22,765	59,614	158,759	2,412,334	256,860	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	95	3,520	9,375	609,486	64,897	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	97	392	1,043	227,809	24,257	90.00
90.01	04950	WOUND CLINIC	7,145	37,953	101,075	1,591,668	169,478	90.01
91.00	09100	EMERGENCY	19,905	134,419	357,978	6,840,039	728,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,892	1,377	3,667	172,628	18,381	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,105	8,634	22,994	1,360,926	144,909	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,204,966	1,463,635	3,898,677	158,317,025	14,568,221	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	177,597	182,199	485,222	50,800,946	5,409,276	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	159	0	0	94,196	10,030	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	61	0	0	692,261	73,711	194.02
194.03	07953	MH RESIDENTIAL	1,893	580	1,546	1,123,538	119,632	194.03
194.04	07954	UNUSED SPACE	0	0	0	3,400,393	362,067	194.04
194.05	07955	MOB	0	0	0	739,528	78,743	194.05
194.06	07956	FOUNDATION	0	0	0	13,997	1,490	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	140,525	14,963	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	2,023	0	0	8,075,310	859,843	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,386,699	1,646,414	4,385,445	223,397,719	21,497,976	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	11,468,215					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	90,814	652,686				8.00
9.00	00900	HOUSEKEEPING	126,512	42,037	3,250,504			9.00
10.00	01000	DIETARY	0	11,146	84,003	1,252,668		10.00
11.00	01100	CAFETERIA	215,895	0	21,264	0	2,369,412	11.00
13.00	01300	NURSING ADMINISTRATION	148,138	0	0	0	33,192	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,552	6,248	38,316	0	23,862	14.00
15.00	01500	PHARMACY	106,732	0	30,141	0	74,207	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	81,347	0	28,937	0	107,960	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	59,359	10,779	93,883	0	27,626	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	6,469	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	6,413	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,204,540	225,715	711,346	497,511	203,098	30.00
31.00	03100	INTENSIVE CARE UNIT	461,091	73,946	264,598	271,587	134,331	31.00
40.00	04000	SUBPROVIDER - IPF	224,777	0	0	167,534	68,736	40.00
41.00	04100	SUBPROVIDER - IRF	296,500	39,560	153,062	278,236	77,043	41.00
43.00	04300	NURSERY	0	2,295	8,877	37,800	10,286	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	326,024	23,946	192,681	0	82,297	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	211,032	15,865	50,753	0	33,858	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,224	12,187	0	41,831	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	569,064	45,758	168,558	0	136,114	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	132,738	0	0	0	59,852	55.00
60.00	06000	LABORATORY	124,822	0	47,393	0	109,978	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	97,937	241	36,259	0	70,770	65.00
66.00	06600	PHYSICAL THERAPY	380,434	9,544	91,877	0	127,578	66.00
69.00	06900	ELECTROCARDIOLOGY	313,539	12,064	143,483	0	96,471	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	131,841	8,654	36,159	0	16,061	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	22,722	151,357	0	46,554	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	148,000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	46,011	185	55,668	0	4,695	90.00
90.01	04950	WOUND CLINIC	49,701	11,104	17,102	0	12,735	90.01
91.00	09100	EMERGENCY	299,087	63,923	221,618	0	170,831	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	6,795	0	0	0	3,940	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	68,482	0	46,641	0	21,253	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,922,764	631,956	2,706,163	1,252,668	1,808,041	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,987,465	20,730	524,281	0	529,372	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	43,734	0	17,001	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	32,542	0	3,059	0	6,475	194.02
194.03	07953	MH RESIDENTIAL	349,392	0	0	0	25,524	194.03
194.04	07954	UNUSED SPACE	1,998,519	0	0	0	0	194.04
194.05	07955	MOB	412,924	0	0	0	0	194.05
194.06	07956	FOUNDATION	8,036	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	81,260	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	631,579	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,468,215	652,686	3,250,504	1,252,668	2,369,412	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,688,828					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	790,820				14.00
15.00	01500	PHARMACY	0	2,791	4,869,789			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	280	0	4,216,537		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	31	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	6	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	276	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	674,435	16,770	3,874	1,281,562	0	30.00
31.00	03100	INTENSIVE CARE UNIT	446,079	12,594	2,838	126,164	0	31.00
40.00	04000	SUBPROVIDER - IPF	228,254	1,198	363	531,217	0	40.00
41.00	04100	SUBPROVIDER - IRF	255,839	3,716	1,856	199,206	0	41.00
43.00	04300	NURSERY	34,158	743	104	53,122	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	273,288	21,495	18,675	99,603	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	19,164	909	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	138,912	3,602	521	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,583	35,488	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,407	891	0	0	55.00
60.00	06000	LABORATORY	0	114,989	764	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,299	442	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,173	1,198	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,700	17,103	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	1,282	8	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	196,837	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	227,976	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,186,505	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	14,441	13,000	763,625	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	60	1,588	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	62	72	0	0	90.00
90.01	04950	WOUND CLINIC	0	4,533	4,740	159,365	0	90.01
91.00	09100	EMERGENCY	567,287	12,627	5,173	1,002,673	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,200	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	70,576	701	128	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,688,828	675,536	4,296,240	4,216,537	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	112,661	573,457	0	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	101	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	38	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	1,201	92	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	1,283	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,688,828	790,820	4,869,789	4,216,537	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH	1,488,188					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		0			22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0			269,846		23.00
23.01	02301	PARAMED ED PRGM-LAB	0				291,989	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	678,885	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	269,846	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	291,989	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0			0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	678,885	0	0	269,846	291,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	809,303	0	0	0	0	194.09
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,488,188	0	0	269,846	291,989	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION					4.03
4.04	00404	PATIENT ACCOUNTS					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	MENTAL HEALTH OH					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY					23.00
23.01	02301	PARAMED ED PRGM-LAB					23.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	14,207,884	0	14,207,884		30.00
31.00	03100	INTENSIVE CARE UNIT	8,383,992	0	8,383,992		31.00
40.00	04000	SUBPROVIDER - IPF	4,865,398	0	4,865,398		40.00
41.00	04100	SUBPROVIDER - IRF	4,421,498	0	4,421,498		41.00
43.00	04300	NURSERY	608,587	0	608,587		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,084,096	0	7,084,096		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
51.01	05101	ENDOSCOPY	2,920,528	0	2,920,528		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,111,193	0	2,111,193		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,658,496	0	10,658,496		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,875,180	0	3,875,180		55.00
60.00	06000	LABORATORY	9,739,263	0	9,739,263		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	3,653,909	0	3,653,909		65.00
66.00	06600	PHYSICAL THERAPY	7,134,730	0	7,134,730		66.00
69.00	06900	ELECTROCARDIOLOGY	6,378,829	0	6,378,829		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	1,310,587	0	1,310,587		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,552,013	0	8,552,013		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,545,107	0	6,545,107		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,053,710	0	22,053,710		73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,680,893	0	3,680,893		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	824,031	0	824,031		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	358,759	0	358,759		90.00
90.01	04950	WOUND CLINIC	2,020,426	0	2,020,426		90.01
91.00	09100	EMERGENCY	9,911,572	0	9,911,572		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	202,944	0	202,944		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	1,713,616	0	1,713,616		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,217,241	0	143,217,241		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,958,188	0	59,958,188		192.00
194.00	07950	COMMUNITY HEALTH SERVICES	165,062	0	165,062		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	808,086	0	808,086		194.02
194.03	07953	MH RESIDENTIAL	1,619,379	0	1,619,379		194.03
194.04	07954	UNUSED SPACE	5,760,979	0	5,760,979		194.04
194.05	07955	MOB	1,231,195	0	1,231,195		194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.06	07956	FOUNDATION	23,523	0	23,523		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	236,748	0	236,748		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	10,377,318	0	10,377,318		194.09
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	223,397,719	0	223,397,719		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	131,810	110	131,920	131,920	4.00
4.01	00401	COMMUNICATIONS	0	0	0	0	359	4.01
4.02	00402	PURCHASING & RECEIVING	0	455,619	379	455,998	887	4.02
4.03	00403	REGISTRATION	0	0	0	0	1,601	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	0	0	3,108	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,236,249	1,145	1,237,394	11,580	5.00
7.00	00700	OPERATION OF PLANT	0	3,832,674	3,451	3,836,125	2,785	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	154,385	132	154,517	264	8.00
9.00	00900	HOUSEKEEPING	0	215,071	184	215,255	2,547	9.00
10.00	01000	DIETARY	0	0	0	0	550	10.00
11.00	01100	CAFETERIA	0	367,023	314	367,337	1,544	11.00
13.00	01300	NURSING ADMINISTRATION	0	251,835	215	252,050	1,824	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,639	2	2,641	469	14.00
15.00	01500	PHARMACY	0	181,444	155	181,599	3,683	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	138,289	118	138,407	3,112	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	100,910	86	100,996	917	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	284	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	274	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,047,721	1,751	2,049,472	5,637	30.00
31.00	03100	INTENSIVE CARE UNIT	0	783,855	670	784,525	4,530	31.00
40.00	04000	SUBPROVIDER - IPF	0	382,121	327	382,448	2,363	40.00
41.00	04100	SUBPROVIDER - IRF	0	504,051	431	504,482	2,213	41.00
43.00	04300	NURSERY	0	0	0	0	380	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	554,242	474	554,716	4,490	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	358,755	307	359,062	1,284	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	1,521	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	967,410	827	968,237	4,890	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	225,655	193	225,848	3,334	55.00
60.00	06000	LABORATORY	0	212,198	182	212,380	2,907	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	166,493	142	166,635	2,746	65.00
66.00	06600	PHYSICAL THERAPY	0	646,738	553	647,291	4,858	66.00
69.00	06900	ELECTROCARDIOLOGY	0	533,017	456	533,473	6,211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	224,130	192	224,322	515	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	1,530	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	251,601	215	251,816	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	78,218	67	78,285	139	90.00
90.01	04950	WOUND CLINIC	0	84,492	72	84,564	511	90.01
91.00	09100	EMERGENCY	0	508,449	435	508,884	5,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	11,551	10	11,561	116	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	116,419	100	116,519	678	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	15,725,064	13,695	15,738,759	91,981	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,378,695	2,890	3,381,585	32,762	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	74,349	64	74,413	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	55,322	47	55,369	215	194.02
194.03	07953	MH RESIDENTIAL	0	593,967	508	594,475	479	194.03
194.04	07954	UNUSED SPACE	0	3,397,487	2,906	3,400,393	0	194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
194.05	07955	MOB	0	701,972	600	702,572	0	194.05
194.06	07956	FOUNDATION	0	13,662	12	13,674	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	138,143	118	138,261	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	1,073,685	918	1,074,603	6,483	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	25,152,346	21,758	25,174,104	131,920	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	359					4.01
4.02	00402	PURCHASING & RECEIVING	3	456,888				4.02
4.03	00403	REGISTRATION	5	206	1,812			4.03
4.04	00404	PATIENT ACCOUNTS	7	314	0	3,429		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	25	1,523	0	0	1,250,522	5.00
7.00	00700	OPERATION OF PLANT	23	4,034	0	0	64,198	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,766	0	0	3,145	8.00
9.00	00900	HOUSEKEEPING	6	4,397	0	0	17,253	9.00
10.00	01000	DIETARY	4	31,640	0	0	6,480	10.00
11.00	01100	CAFETERIA	0	0	0	0	11,936	11.00
13.00	01300	NURSING ADMINISTRATION	3	172	0	0	14,037	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	2,093	0	0	4,035	14.00
15.00	01500	PHARMACY	5	1,450	0	0	26,064	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8	145	0	0	22,381	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	35	16	0	0	7,258	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	3	0	0	1,474	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	143	0	0	1,597	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24	8,710	89	149	52,559	30.00
31.00	03100	INTENSIVE CARE UNIT	15	6,541	60	100	36,895	31.00
40.00	04000	SUBPROVIDER - IPF	0	622	24	40	16,595	40.00
41.00	04100	SUBPROVIDER - IRF	11	1,930	24	40	17,446	41.00
43.00	04300	NURSERY	0	386	4	7	2,582	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24	11,165	170	283	33,846	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	4	9,953	36	60	14,493	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	15	1,871	20	33	10,680	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11	3,419	88	557	52,772	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6	1,770	69	115	20,591	55.00
60.00	06000	LABORATORY	5	59,724	206	343	50,658	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	6	1,713	51	85	19,285	65.00
66.00	06600	PHYSICAL THERAPY	5	609	77	128	36,515	66.00
69.00	06900	ELECTROCARDIOLOGY	13	1,922	142	236	32,426	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	3	666	17	28	6,251	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	102,235	0	0	46,772	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	118,408	0	0	35,363	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	212	353	100,020	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	7,501	73	121	14,942	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	31	4	7	3,775	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1	32	0	1	1,411	90.00
90.01	04950	WOUND CLINIC	2	2,354	46	77	9,859	90.01
91.00	09100	EMERGENCY	16	6,558	164	273	42,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	623	2	3	1,069	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4	364	11	18	8,430	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	290	397,009	1,589	3,057	847,460	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	63	58,515	222	371	314,614	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	3	53	0	0	583	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	1	20	0	0	4,288	194.02
194.03	07953	MH RESIDENTIAL	0	624	1	1	6,959	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	21,062	194.04
194.05	07955	MOB	0	0	0	0	4,581	194.05
194.06	07956	FOUNDATION	0	0	0	0	87	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	2	0	0	0	870	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	667	0	0	50,018	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	359	456,888	1,812	3,429	1,250,522	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	3,907,165					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,940	190,632				8.00
9.00	00900	HOUSEKEEPING	43,102	12,278	294,838			9.00
10.00	01000	DIETARY	0	3,255	7,620	49,549		10.00
11.00	01100	CAFETERIA	73,554	0	1,929	0	456,300	11.00
13.00	01300	NURSING ADMINISTRATION	50,470	0	0	0	6,392	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	529	1,825	3,475	0	4,595	14.00
15.00	01500	PHARMACY	36,363	0	2,734	0	14,291	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,714	0	2,625	0	20,791	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	20,223	3,148	8,516	0	5,320	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	1,246	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	1,235	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	410,381	65,926	64,522	19,678	39,112	30.00
31.00	03100	INTENSIVE CARE UNIT	157,091	21,598	24,000	10,743	25,869	31.00
40.00	04000	SUBPROVIDER - IPF	76,580	0	0	6,627	13,237	40.00
41.00	04100	SUBPROVIDER - IRF	101,016	11,554	13,884	11,006	14,837	41.00
43.00	04300	NURSERY	0	670	805	1,495	1,981	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	111,075	6,994	17,477	0	15,849	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	71,898	4,634	4,604	0	6,520	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,818	1,105	0	8,056	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	193,877	13,365	15,289	0	26,213	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	45,223	0	0	0	11,526	55.00
60.00	06000	LABORATORY	42,526	0	4,299	0	21,179	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	33,367	70	3,289	0	13,629	65.00
66.00	06600	PHYSICAL THERAPY	129,612	2,787	8,334	0	24,569	66.00
69.00	06900	ELECTROCARDIOLOGY	106,821	3,524	13,015	0	18,578	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	44,918	2,528	3,280	0	3,093	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	6,636	13,729	0	8,965	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	50,423	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,676	54	5,049	0	904	90.00
90.01	04950	WOUND CLINIC	16,933	3,243	1,551	0	2,452	90.01
91.00	09100	EMERGENCY	101,898	18,670	20,102	0	32,899	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,315	0	0	0	759	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	23,331	0	4,231	0	4,093	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,017,856	184,577	245,464	49,549	348,190	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	677,119	6,055	47,555	0	101,948	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	14,900	0	1,542	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	11,087	0	277	0	1,247	194.02
194.03	07953	MH RESIDENTIAL	119,036	0	0	0	4,915	194.03
194.04	07954	UNUSED SPACE	680,887	0	0	0	0	194.04
194.05	07955	MOB	140,681	0	0	0	0	194.05
194.06	07956	FOUNDATION	2,738	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	27,685	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	215,176	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,907,165	190,632	294,838	49,549	456,300	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	324,948					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,663				14.00
15.00	01500	PHARMACY	0	69	266,258			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7	0	215,190		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	1	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	7	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,506	417	212	65,405	0	30.00
31.00	03100	INTENSIVE CARE UNIT	53,909	313	155	6,439	0	31.00
40.00	04000	SUBPROVIDER - IPF	27,585	30	20	27,111	0	40.00
41.00	04100	SUBPROVIDER - IRF	30,919	92	102	10,166	0	41.00
43.00	04300	NURSERY	4,128	18	6	2,711	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,027	535	1,021	5,083	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	477	50	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,788	90	28	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	164	1,940	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	85	49	0	0	55.00
60.00	06000	LABORATORY	0	2,860	42	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	82	24	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	29	66	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	92	935	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	32	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,895	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,664	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	228,897	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	359	711	38,971	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	1	87	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2	4	0	0	90.00
90.01	04950	WOUND CLINIC	0	113	259	8,133	0	90.01
91.00	09100	EMERGENCY	68,557	314	283	51,171	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	30	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	8,529	17	7	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	324,948	16,795	234,898	215,190	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,802	31,355	0	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	3	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	1	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	30	5	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	32	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	324,948	19,663	266,258	215,190	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH	146,430					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		0			22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0			3,007		23.00
23.01	02301	PARAMED ED PRGM-LAB	0				3,256	23.01
		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	66,795					40.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
43.00	04300	NURSERY	0					43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
51.01	05101	ENDOSCOPY	0					51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0					52.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0					55.00
60.00	06000	LABORATORY	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0					63.00
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
70.01	07001	NEURODIAGNOSTICS	0					70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0					75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0					76.00
76.01	03951	INPATIENT DIALYSIS	0					76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0					90.00
90.01	04950	WOUND CLINIC	0					90.01
91.00	09100	EMERGENCY	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0					96.00
101.00	10100	HOME HEALTH AGENCY	0					101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0					116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,795	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0					194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0					194.02
194.03	07953	MH RESIDENTIAL	0					194.03
194.04	07954	UNUSED SPACE	0					194.04
194.05	07955	MOB	0					194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	MENTAL HEALTH OH	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
			17.01	21.00	22.00	23.00	23.01	
194.06	07956	FOUNDATION	0					194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0					194.07
194.08	07958	INDUSTRIAL HEALTH	0					194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	79,635					194.09
200.00		Cross Foot Adjustments		0	0	3,007	3,256	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	146,430	0	0	3,007	3,256	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION					4.03
4.04	00404	PATIENT ACCOUNTS					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	MENTAL HEALTH OH					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY					23.00
23.01	02301	PARAMED ED PRGM-LAB					23.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,863,799	0	2,863,799		30.00
31.00	03100	INTENSIVE CARE UNIT	1,132,783	0	1,132,783		31.00
40.00	04000	SUBPROVIDER - IPF	620,077	0	620,077		40.00
41.00	04100	SUBPROVIDER - IRF	719,722	0	719,722		41.00
43.00	04300	NURSERY	15,173	0	15,173		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	795,755	0	795,755		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
51.01	05101	ENDOSCOPY	473,075	0	473,075		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,025	0	42,025		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,280,822	0	1,280,822		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	308,616	0	308,616		55.00
60.00	06000	LABORATORY	397,129	0	397,129		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	240,982	0	240,982		65.00
66.00	06600	PHYSICAL THERAPY	854,880	0	854,880		66.00
69.00	06900	ELECTROCARDIOLOGY	717,388	0	717,388		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	285,653	0	285,653		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,902	0	153,902		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	159,435	0	159,435		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	329,482	0	329,482		73.00
75.00	07500	ASC (NON-DISTINCT PART)	93,538	0	93,538		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	306,144	0	306,144		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	101,558	0	101,558		90.00
90.01	04950	WOUND CLINIC	130,097	0	130,097		90.01
91.00	09100	EMERGENCY	857,496	0	857,496		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	16,478	0	16,478		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	166,232	0	166,232		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,062,241	0	13,062,241		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,654,966	0	4,654,966		192.00
194.00	07950	COMMUNITY HEALTH SERVICES	91,497	0	91,497		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	72,505	0	72,505		194.02
194.03	07953	MH RESIDENTIAL	726,525	0	726,525		194.03
194.04	07954	UNUSED SPACE	4,102,342	0	4,102,342		194.04
194.05	07955	MOB	847,834	0	847,834		194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.06	07956	FOUNDATION	16,499	0	16,499		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	166,818	0	166,818		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	1,426,614	0	1,426,614		194.09
200.00		Cross Foot Adjustments	6,263	0	6,263		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	25,174,104	0	25,174,104		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			1.00	2.00	4.00	4.01	4.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	857,937					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		867,686				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,496	4,401	103,277,171			4.00
4.01	00401	COMMUNICATIONS	0	0	280,900	2,237		4.01
4.02	00402	PURCHASING & RECEIVING	15,541	15,121	694,499	18	20,639,427	4.02
4.03	00403	REGISTRATION	0	0	1,253,808	32	9,284	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	2,433,659	43	14,169	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	42,168	45,660	9,068,076	153	68,816	5.00
7.00	00700	OPERATION OF PLANT	130,731	137,503	2,180,898	145	182,219	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,266	5,266	206,759	0	79,786	8.00
9.00	00900	HOUSEKEEPING	7,336	7,336	1,994,584	37	198,606	9.00
10.00	01000	DIETARY	0	0	430,514	28	1,429,280	10.00
11.00	01100	CAFETERIA	12,519	12,519	1,209,046	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,590	8,590	1,428,144	20	7,784	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90	90	367,321	9	94,564	14.00
15.00	01500	PHARMACY	6,189	6,189	2,883,987	32	65,481	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,717	4,717	2,436,861	52	6,570	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	3,442	3,442	717,946	220	739	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	222,786	0	147	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	214,465	0	6,481	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,847	69,847	4,414,604	147	393,477	30.00
31.00	03100	INTENSIVE CARE UNIT	26,737	26,737	3,547,217	95	295,487	31.00
40.00	04000	SUBPROVIDER - IPF	13,034	13,034	1,850,794	0	28,104	40.00
41.00	04100	SUBPROVIDER - IRF	17,193	17,193	1,732,693	70	87,191	41.00
43.00	04300	NURSERY	0	0	297,324	0	17,440	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,905	18,905	3,516,189	148	504,337	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	12,237	12,237	1,005,330	26	449,630	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,191,158	92	84,502	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,998	32,998	3,829,231	66	154,462	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,697	7,697	2,610,961	37	79,947	55.00
60.00	06000	LABORATORY	7,238	7,238	2,276,662	32	2,697,931	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,679	5,679	2,150,183	39	77,400	65.00
66.00	06600	PHYSICAL THERAPY	22,060	22,060	3,804,055	33	27,519	66.00
69.00	06900	ELECTROCARDIOLOGY	18,181	18,181	4,863,753	78	86,812	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	7,645	7,645	402,980	20	30,077	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,618,301	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,349,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	1,198,091	0	338,831	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	8,582	8,582	0	3	1,407	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,668	2,668	108,848	9	1,450	90.00
90.01	04950	WOUND CLINIC	2,882	2,882	400,108	10	106,349	90.01
91.00	09100	EMERGENCY	17,343	17,343	4,181,575	101	296,265	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	394	394	91,223	0	28,158	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,971	3,971	531,026	23	16,450	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	536,376	546,125	72,028,258	1,818	17,934,554	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	115,246	115,246	25,628,847	376	2,643,320	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	2,536	2,536	0	21	2,373	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,887	1,887	168,477	6	902	194.02
194.03	07953	MH RESIDENTIAL	20,260	20,260	375,014	0	28,168	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			1.00	2.00	4.00	4.01	4.02	
194.04	07954	UNUSED SPACE	115,887	115,887	0	0	0	194.04
194.05	07955	MOB	23,944	23,944	0	0	0	194.05
194.06	07956	FOUNDATION	466	466	0	2	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	4,712	4,712	0	14	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	36,623	36,623	5,076,575	0	30,110	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	25,152,346	21,758	29,391,749	361,680	1,386,699	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.317241	0.025076	0.284591	161.680823	0.067187	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			131,920	359	456,888	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001277	0.160483	0.022137	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION	669,945,864					4.03
4.04	00404	PATIENT ACCOUNTS	0	669,945,864				4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	-21,497,976	201,899,743		5.00
7.00	00700	OPERATION OF PLANT	0	0	0	10,364,612	665,001	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	507,802	5,266	8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,785,374	7,336	9.00
10.00	01000	DIETARY	0	0	0	1,046,129	0	10.00
11.00	01100	CAFETERIA	0	0	0	1,927,063	12,519	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,266,198	8,590	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	651,474	90	14.00
15.00	01500	PHARMACY	0	0	0	4,207,872	6,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,613,278	4,717	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	0	0	1,171,745	3,442	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	238,026	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	257,845	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,751,482	29,751,482	0	8,485,513	69,847	30.00
31.00	03100	INTENSIVE CARE UNIT	20,042,310	20,042,310	0	5,956,525	26,737	31.00
40.00	04000	SUBPROVIDER - IPF	8,090,436	8,090,436	0	2,679,162	13,034	40.00
41.00	04100	SUBPROVIDER - IRF	8,016,365	8,016,365	0	2,816,577	17,193	41.00
43.00	04300	NURSERY	1,459,353	1,459,353	0	416,820	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,691,384	56,691,384	0	5,464,263	18,905	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	11,904,684	11,904,684	0	2,339,809	12,237	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,650,915	6,650,915	0	1,724,314	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,411,564	95,411,564	0	8,519,903	32,998	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	23,054,825	23,054,825	0	3,324,325	7,697	55.00
60.00	06000	LABORATORY	68,511,021	68,511,021	0	8,178,498	7,238	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	16,905,871	16,905,871	0	3,113,447	5,679	65.00
66.00	06600	PHYSICAL THERAPY	25,641,478	25,641,478	0	5,895,215	22,060	66.00
69.00	06900	ELECTROCARDIOLOGY	47,235,284	47,235,284	0	5,235,051	18,181	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	5,648,354	5,648,354	0	1,009,132	7,645	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,213	4,213	0	7,551,145	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,709,224	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,520,752	70,520,752	0	16,147,818	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	24,252,866	24,252,866	0	2,412,334	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,432,189	1,432,189	0	609,486	8,582	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	159,344	159,344	0	227,809	2,668	90.00
90.01	04950	WOUND CLINIC	15,440,730	15,440,730	0	1,591,668	2,882	90.01
91.00	09100	EMERGENCY	54,686,500	54,686,500	0	6,840,039	17,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	560,220	560,220	0	172,628	394	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,512,644	3,512,644	0	1,360,926	3,971	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	595,584,784	595,584,784	-21,497,976	136,819,049	343,440	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	74,124,970	74,124,970	0	50,800,946	115,246	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	94,196	2,536	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	692,261	1,887	194.02
194.03	07953	MH RESIDENTIAL	236,110	236,110	0	1,123,538	20,260	194.03
194.04	07954	UNUSED SPACE	0	0	0	3,400,393	115,887	194.04
194.05	07955	MOB	0	0	0	739,528	23,944	194.05
194.06	07956	FOUNDATION	0	0	0	13,997	466	194.06

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	140,525	4,712	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	8,075,310	36,623	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,646,414	4,385,445		21,497,976	11,468,215	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002458	0.006546		0.106478	17.245410	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,812	3,429		1,250,522	3,907,165	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000003	0.000005		0.006194	5.875427	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	986,451					8.00
9.00	00900	HOUSEKEEPING	63,534	64,814				9.00
10.00	01000	DIETARY	16,845	1,675	32,974			10.00
11.00	01100	CAFETERIA	0	424	0	2,286,691		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	32,033	781,437	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,443	764	0	23,029	0	14.00
15.00	01500	PHARMACY	0	601	0	71,616	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	577	0	104,191	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	16,291	1,872	0	26,662	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	6,243	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	6,189	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	341,140	14,184	13,096	196,007	196,007	30.00
31.00	03100	INTENSIVE CARE UNIT	111,760	5,276	7,149	129,641	129,641	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,410	66,336	66,336	40.00
41.00	04100	SUBPROVIDER - IRF	59,790	3,052	7,324	74,353	74,353	41.00
43.00	04300	NURSERY	3,468	177	995	9,927	9,927	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,192	3,842	0	79,424	79,424	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	23,978	1,012	0	32,676	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,407	243	0	40,371	40,371	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,157	3,361	0	131,362	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	57,762	0	55.00
60.00	06000	LABORATORY	0	945	0	106,138	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	364	723	0	68,299	0	65.00
66.00	06600	PHYSICAL THERAPY	14,424	1,832	0	123,124	0	66.00
69.00	06900	ELECTROCARDIOLOGY	18,233	2,861	0	93,103	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	13,079	721	0	15,500	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	34,341	3,018	0	44,929	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	280	1,110	0	4,531	0	90.00
90.01	04950	WOUND CLINIC	16,783	341	0	12,290	0	90.01
91.00	09100	EMERGENCY	96,611	4,419	0	164,867	164,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	3,802	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	930	0	20,511	20,511	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	955,120	53,960	32,974	1,744,916	781,437	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,331	10,454	0	510,893	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	339	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	61	0	6,249	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	24,633	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	652,686	3,250,504	1,252,668	2,369,412	2,688,828	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.661651	50.151264	37.989568	1.036175	3.440876	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	190,632	294,838	49,549	456,300	324,948	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.193250	4.548986	1.502669	0.199546	0.415834	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,554,919					14.00
15.00	01500	PHARMACY	65,481	16,440,038				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,570	0	635			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
17.01	01701	MENTAL HEALTH OH	739	0	0	0	17,735,173	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	147	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	6,481	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	393,477	13,078	193	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	295,487	9,582	19	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	28,104	1,224	80	0	8,090,436	40.00
41.00	04100	SUBPROVIDER - IRF	87,191	6,267	30	0	0	41.00
43.00	04300	NURSERY	17,440	352	8	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	504,337	63,047	15	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	449,630	3,068	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,502	1,759	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	154,462	119,804	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	79,947	3,008	0	0	0	55.00
60.00	06000	LABORATORY	2,697,931	2,580	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	77,400	1,492	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	27,519	4,045	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	86,812	57,737	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	30,077	28	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,618,301	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,349,101	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,133,319	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	338,831	43,886	115	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,407	5,362	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,450	242	0	0	0	90.00
90.01	04950	WOUND CLINIC	106,349	16,002	24	0	0	90.01
91.00	09100	EMERGENCY	296,265	17,462	151	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	28,158	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	16,450	432	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,850,046	14,503,776	635	0	8,090,436	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,643,320	1,935,950	0	0	0	192.00
194.00	07950	COMMUNITY HEALTH SERVICES	2,373	0	0	0	0	194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	902	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	28,168	312	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	30,110	0	0	0	9,644,737	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	790,820	4,869,789	4,216,537	0	1,488,188	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.042621	0.296215	6,640.215748	0.000000	0.083912	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,663	266,258	215,190	0	146,430	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001060	0.016196	338.881890	0.000000	0.008256	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LAB (ASSIGNED TIME)		
			21.00	22.00	23.00	23.01		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	MENTAL HEALTH OH						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0				22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY			100			23.00
23.01	02301	PARAMED ED PRGM-LAB				100		23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	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		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
51.01	05101	ENDOSCOPY	0	0	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	100	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
60.00	06000	LABORATORY	0	0	0	100		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	04950	WOUND CLINIC	0	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	100	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0		194.00
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0		194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0		194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/20/2020 10:18 am

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LAB (ASSIGNED TIME)		
			21.00	22.00	23.00	23.01		
194.04	07954	UNUSED SPACE	0	0	0	0		194.04
194.05	07955	MOB	0	0	0	0		194.05
194.06	07956	FOUNDATION	0	0	0	0		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	0		194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	269,846	291,989		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	2,698.460000	2,919.890000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	3,007	3,256		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	30.070000	32.560000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 1/20/2020 10:18 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,207,884		14,207,884	0	14,207,884	30.00
31.00	03100	INTENSIVE CARE UNIT	8,383,992		8,383,992	0	8,383,992	31.00
40.00	04000	SUBPROVIDER - IPF	4,865,398		4,865,398	0	4,865,398	40.00
41.00	04100	SUBPROVIDER - IRF	4,421,498		4,421,498	0	4,421,498	41.00
43.00	04300	NURSERY	608,587		608,587	0	608,587	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,084,096		7,084,096	0	7,084,096	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	2,920,528		2,920,528	0	2,920,528	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,111,193		2,111,193	0	2,111,193	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,658,496		10,658,496	0	10,658,496	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,875,180		3,875,180	15,934	3,891,114	55.00
60.00	06000	LABORATORY	9,739,263		9,739,263	0	9,739,263	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,653,909	0	3,653,909	0	3,653,909	65.00
66.00	06600	PHYSICAL THERAPY	7,134,730	0	7,134,730	0	7,134,730	66.00
69.00	06900	ELECTROCARDIOLOGY	6,378,829		6,378,829	36,919	6,415,748	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,310,587		1,310,587	11,289	1,321,876	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,552,013		8,552,013	0	8,552,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,545,107		6,545,107	0	6,545,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,053,710		22,053,710	0	22,053,710	73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,680,893		3,680,893	3,166	3,684,059	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	824,031		824,031	5,835	829,866	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	358,759		358,759	0	358,759	90.00
90.01	04950	WOUND CLINIC	2,020,426		2,020,426	0	2,020,426	90.01
91.00	09100	EMERGENCY	9,911,572		9,911,572	23,798	9,935,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,444,730		3,444,730		3,444,730	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	202,944		202,944	0	202,944	96.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,713,616		1,713,616		1,713,616	116.00
200.00		Subtotal (see instructions)	146,661,971	0	146,661,971	96,941	146,758,912	200.00
201.00		Less Observation Beds	3,444,730		3,444,730		3,444,730	201.00
202.00		Total (see instructions)	143,217,241	0	143,217,241	96,941	143,314,182	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 1/20/2020 10:18 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,518,818		26,518,818			30.00
31.00	03100	INTENSIVE CARE UNIT	18,525,338		18,525,338			31.00
40.00	04000	SUBPROVIDER - IPF	8,036,814		8,036,814			40.00
41.00	04100	SUBPROVIDER - IRF	7,995,044		7,995,044			41.00
43.00	04300	NURSERY	1,433,876		1,433,876			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,622,420	20,850,285	41,472,705	0.170813	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,501,784	10,103,869	11,605,653	0.251647	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,145,272	195,481	6,340,753	0.332956	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,310,470	76,627,022	92,937,492	0.114685	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	412,904	22,442,634	22,855,538	0.169551	0.000000	55.00
60.00	06000	LABORATORY	21,390,714	47,120,307	68,511,021	0.142156	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	11,899,184	3,020,829	14,920,013	0.244900	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	14,941,685	10,690,366	25,632,051	0.278352	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	16,336,356	20,174,171	36,510,527	0.174712	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	86,356	5,534,998	5,621,354	0.233144	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,785,698	4,077,745	7,863,443	1.087566	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,132,871	6,036,676	14,169,547	0.461914	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,371,626	59,692,989	81,064,615	0.272051	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	195,657	20,444,245	20,639,902	0.178339	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	1,327,405	104,784	1,432,189	0.575365	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	159,344	159,344	2.251475	0.000000	90.00
90.01	04950	WOUND CLINIC	186,129	7,199,681	7,385,810	0.273555	0.000000	90.01
91.00	09100	EMERGENCY	10,916,458	41,893,031	52,809,489	0.187685	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,453,029	5,386,921	6,839,950	0.503619	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	560,220	560,220	0.362258	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,994	3,507,651	3,512,645			116.00
200.00		Subtotal (see instructions)	219,530,902	365,823,249	585,354,151			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	219,530,902	365,823,249	585,354,151			202.00

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.170813	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
51.01	05101	ENDOSCOPY	0.251647	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.332956	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114685	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.170248	55.00
60.00	06000	LABORATORY	0.142156	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.244900	65.00
66.00	06600	PHYSICAL THERAPY	0.278352	66.00
69.00	06900	ELECTROCARDIOLOGY	0.175723	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0.235153	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.087566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272051	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.178492	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0.579439	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	2.251475	90.00
90.01	04950	WOUND CLINIC	0.273555	90.01
91.00	09100	EMERGENCY	0.188136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503619	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.362258	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 1/20/2020 10:18 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	14,207,884		14,207,884	0	14,207,884	30.00
31.00	03100	INTENSIVE CARE UNIT	8,383,992		8,383,992	0	8,383,992	31.00
40.00	04000	SUBPROVIDER - IPF	4,865,398		4,865,398	0	4,865,398	40.00
41.00	04100	SUBPROVIDER - IRF	4,421,498		4,421,498	0	4,421,498	41.00
43.00	04300	NURSERY	608,587		608,587	0	608,587	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,084,096		7,084,096	0	7,084,096	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	2,920,528		2,920,528	0	2,920,528	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,111,193		2,111,193	0	2,111,193	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,658,496		10,658,496	0	10,658,496	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,875,180		3,875,180	15,934	3,891,114	55.00
60.00	06000	LABORATORY	9,739,263		9,739,263	0	9,739,263	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,653,909	0	3,653,909	0	3,653,909	65.00
66.00	06600	PHYSICAL THERAPY	7,134,730	0	7,134,730	0	7,134,730	66.00
69.00	06900	ELECTROCARDIOLOGY	6,378,829		6,378,829	36,919	6,415,748	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,310,587		1,310,587	11,289	1,321,876	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,552,013		8,552,013	0	8,552,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,545,107		6,545,107	0	6,545,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,053,710		22,053,710	0	22,053,710	73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,680,893		3,680,893	3,166	3,684,059	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	824,031		824,031	5,835	829,866	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	358,759		358,759	0	358,759	90.00
90.01	04950	WOUND CLINIC	2,020,426		2,020,426	0	2,020,426	90.01
91.00	09100	EMERGENCY	9,911,572		9,911,572	23,798	9,935,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,444,730		3,444,730		3,444,730	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	202,944		202,944	0	202,944	96.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,713,616		1,713,616		1,713,616	116.00
200.00		Subtotal (see instructions)	146,661,971	0	146,661,971	96,941	146,758,912	200.00
201.00		Less Observation Beds	3,444,730		3,444,730		3,444,730	201.00
202.00		Total (see instructions)	143,217,241	0	143,217,241	96,941	143,314,182	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 1/20/2020 10:18 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	26,518,818		26,518,818			30.00
31.00	03100	INTENSIVE CARE UNIT	18,525,338		18,525,338			31.00
40.00	04000	SUBPROVIDER - IPF	8,036,814		8,036,814			40.00
41.00	04100	SUBPROVIDER - IRF	7,995,044		7,995,044			41.00
43.00	04300	NURSERY	1,433,876		1,433,876			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,622,420	20,850,285	41,472,705	0.170813	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,501,784	10,103,869	11,605,653	0.251647	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,145,272	195,481	6,340,753	0.332956	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,310,470	76,627,022	92,937,492	0.114685	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	412,904	22,442,634	22,855,538	0.169551	0.000000	55.00
60.00	06000	LABORATORY	21,390,714	47,120,307	68,511,021	0.142156	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	11,899,184	3,020,829	14,920,013	0.244900	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	14,941,685	10,690,366	25,632,051	0.278352	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	16,336,356	20,174,171	36,510,527	0.174712	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	86,356	5,534,998	5,621,354	0.233144	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,785,698	4,077,745	7,863,443	1.087566	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,132,871	6,036,676	14,169,547	0.461914	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,371,626	59,692,989	81,064,615	0.272051	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	195,657	20,444,245	20,639,902	0.178339	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	1,327,405	104,784	1,432,189	0.575365	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	159,344	159,344	2.251475	0.000000	90.00
90.01	04950	WOUND CLINIC	186,129	7,199,681	7,385,810	0.273555	0.000000	90.01
91.00	09100	EMERGENCY	10,916,458	41,893,031	52,809,489	0.187685	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,453,029	5,386,921	6,839,950	0.503619	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	560,220	560,220	0.362258	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,994	3,507,651	3,512,645			116.00
200.00		Subtotal (see instructions)	219,530,902	365,823,249	585,354,151			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	219,530,902	365,823,249	585,354,151			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 1/20/2020 10:18 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	ENDOSCOPY	0.000000		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	NEURODIAGNOSTICS	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000		76.00
76.01	03951	INPATIENT DIALYSIS	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	WOUND CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 1/20/2020 10:18 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	2,863,799	0	2,863,799	17,158	166.91	30.00
31.00	INTENSIVE CARE UNIT	1,132,783		1,132,783	7,149	158.45	31.00
40.00	SUBPROVIDER - IPF	620,077	0	620,077	4,410	140.61	40.00
41.00	SUBPROVIDER - IRF	719,722	0	719,722	7,324	98.27	41.00
43.00	NURSERY	15,173		15,173	995	15.25	43.00
200.00	Total (lines 30 through 199)	5,351,554		5,351,554	37,036		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	8,314	1,387,690	30.00
31.00	INTENSIVE CARE UNIT	4,530	717,779	31.00
40.00	SUBPROVIDER - IPF	1,645	231,303	40.00
41.00	SUBPROVIDER - IRF	6,323	621,361	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	20,812	2,958,133	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 1/20/2020 10:18 am

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	795,755	41,472,705	0.019187	11,061,820	212,243	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	473,075	11,605,653	0.040762	936,648	38,180	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,025	6,340,753	0.006628	3,697	25	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,280,822	92,937,492	0.013782	9,812,380	135,234	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	308,616	22,855,538	0.013503	244,548	3,302	55.00
60.00	06000	LABORATORY	397,129	68,511,021	0.005797	12,893,811	74,745	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	240,982	14,920,013	0.016152	6,273,199	101,325	65.00
66.00	06600	PHYSICAL THERAPY	854,880	25,632,051	0.033352	3,984,960	132,906	66.00
69.00	06900	ELECTROCARDIOLOGY	717,388	36,510,527	0.019649	8,414,658	165,340	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	285,653	5,621,354	0.050816	45,819	2,328	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,902	7,863,443	0.019572	2,200,771	43,073	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	159,435	14,169,547	0.011252	4,721,754	53,129	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	329,482	81,064,615	0.004064	11,391,050	46,293	73.00
75.00	07500	ASC (NON-DISTINCT PART)	93,538	20,639,902	0.004532	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	306,144	1,432,189	0.213759	1,000,921	213,956	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	101,558	159,344	0.637351	0	0	90.00
90.01	04950	WOUND CLINIC	130,097	7,385,810	0.017614	25,305	446	90.01
91.00	09100	EMERGENCY	857,496	52,809,489	0.016238	6,384,619	103,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	694,334	6,839,950	0.101512	1,082,631	109,900	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	16,478	560,220	0.029413	0	0	96.00
200.00		Total (lines 50 through 199)	8,238,789	519,331,616		80,478,591	1,436,098	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 1/20/2020 10:18 am

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	17,158	0.00	8,314	30.00
31.00	03100	INTENSIVE CARE UNIT		0	7,149	0.00	4,530	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,410	0.00	1,645	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	7,324	0.00	6,323	41.00
43.00	04300	NURSERY		0	995	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	37,036		20,812	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 1/20/2020 10:18 am

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	269,846	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	291,989	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	561,835	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	41,472,705	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	11,605,653	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,340,753	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	269,846	269,846	92,937,492	0.002904	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	22,855,538	0.000000	55.00
60.00	06000	LABORATORY	0	291,989	291,989	68,511,021	0.004262	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,920,013	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,632,051	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,510,527	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,621,354	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,863,443	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,169,547	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	81,064,615	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	20,639,902	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,432,189	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	159,344	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	7,385,810	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	52,809,489	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,839,950	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	560,220	0.000000	96.00
200.00		Total (lines 50 through 199)	0	561,835	561,835	519,331,616		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 1/20/2020 10:18 am

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	11,061,820	0	8,499,760	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	936,648	0	3,824,870	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,697	0	5,662	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.002904	9,812,380	28,495	30,323,928	88,061	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	244,548	0	12,888,776	0	55.00
60.00	06000	LABORATORY	0.004262	12,893,811	54,953	7,806,081	33,270	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,273,199	0	1,527,229	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,984,960	0	388,156	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,414,658	0	10,011,241	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	45,819	0	2,114,651	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,200,771	0	1,701,199	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,721,754	0	3,198,385	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	11,391,050	0	29,106,295	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	7,170,237	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	1,000,921	0	63,648	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	302	0	90.00
90.01	04950	WOUND CLINIC	0.000000	25,305	0	4,534,776	0	90.01
91.00	09100	EMERGENCY	0.000000	6,384,619	0	10,774,214	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,082,631	0	3,386,551	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		80,478,591	83,448	137,325,961	121,331	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 1/20/2020 10:18 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	0.170813	8,499,760	0	0	1,451,870	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.251647	3,824,870	0	0	962,517	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.332956	5,662	0	0	1,885	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114685	30,323,928	0	0	3,477,700	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.169551	12,888,776	0	0	2,185,305	55.00
60.00	06000	LABORATORY	0.142156	7,806,081	0	0	1,109,681	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.244900	1,527,229	0	0	374,018	65.00
66.00	06600	PHYSICAL THERAPY	0.278352	388,156	0	0	108,044	66.00
69.00	06900	ELECTROCARDIOLOGY	0.174712	10,011,241	0	0	1,749,084	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233144	2,114,651	0	0	493,018	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.087566	1,701,199	0	0	1,850,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461914	3,198,385	0	0	1,477,379	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272051	29,106,295	0	44,042	7,918,397	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.178339	7,170,237	0	0	1,278,733	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.575365	63,648	0	0	36,621	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.251475	302	0	0	680	90.00
90.01	04950	WOUND CLINIC	0.273555	4,534,776	0	0	1,240,511	90.01
91.00	09100	EMERGENCY	0.187685	10,774,214	0	144	2,022,158	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503619	3,386,551	0	0	1,705,531	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.362258	0	0	0	0	96.00
200.00		Subtotal (see instructions)		137,325,961	0	44,186	29,443,298	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		137,325,961	0	44,186	29,443,298	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 1/20/2020 10:18 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
51.01	05101	ENDOSCOPY	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,982		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	27		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	12,009		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	12,009		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II | Date/Time Prepared: 1/20/2020 10:18 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	795,755	41,472,705	0.019187	1,254	24	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	473,075	11,605,653	0.040762	1,507	61	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,025	6,340,753	0.006628	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,280,822	92,937,492	0.013782	32,897	453	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	308,616	22,855,538	0.013503	0	0	55.00
60.00	06000	LABORATORY	397,129	68,511,021	0.005797	86,290	500	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	240,982	14,920,013	0.016152	185,098	2,990	65.00
66.00	06600	PHYSICAL THERAPY	854,880	25,632,051	0.033352	19,845	662	66.00
69.00	06900	ELECTROCARDIOLOGY	717,388	36,510,527	0.019649	6,546	129	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	285,653	5,621,354	0.050816	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,902	7,863,443	0.019572	2,846	56	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	159,435	14,169,547	0.011252	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	329,482	81,064,615	0.004064	340,229	1,383	73.00
75.00	07500	ASC (NON-DISTINCT PART)	93,538	20,639,902	0.004532	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	306,144	1,432,189	0.213759	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	101,558	159,344	0.637351	0	0	90.00
90.01	04950	WOUND CLINIC	130,097	7,385,810	0.017614	0	0	90.01
91.00	09100	EMERGENCY	857,496	52,809,489	0.016238	9,130	148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,839,950	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	16,478	560,220	0.029413	0	0	96.00
200.00		Total (lines 50 through 199)	7,544,455	519,331,616		685,642	6,406	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	269,846	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	291,989	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	561,835	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	41,472,705	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	11,605,653	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,340,753	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	269,846	269,846	92,937,492	0.002904	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	22,855,538	0.000000	55.00
60.00	06000	LABORATORY	0	291,989	291,989	68,511,021	0.004262	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,920,013	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,632,051	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,510,527	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,621,354	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,863,443	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,169,547	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	81,064,615	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	20,639,902	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,432,189	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	159,344	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	7,385,810	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	52,809,489	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,839,950	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	560,220	0.000000	96.00
200.00		Total (lines 50 through 199)	0	561,835	561,835	519,331,616		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/20/2020 10:18 am

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,254	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	1,507	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.002904	32,897	96	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.004262	86,290	368	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	185,098	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	19,845	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,546	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,846	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	340,229	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	9,130	0	943	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		685,642	464	943	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.170813	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.251647	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.332956	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114685	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.169551	0	0	0	0	55.00
60.00	06000	LABORATORY	0.142156	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.244900	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.278352	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.174712	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233144	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.087566	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461914	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272051	0	0	364	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.178339	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.575365	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.251475	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.273555	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.187685	943	0	0	177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503619	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.362258	0	0	0	0	96.00
200.00		Subtotal (see instructions)		943	0	364	177	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		943	0	364	177	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	99		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	99		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	99		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	795,755	41,472,705	0.019187	10,943	210	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	473,075	11,605,653	0.040762	6,107	249	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,025	6,340,753	0.006628	453	3	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,280,822	92,937,492	0.013782	449,949	6,201	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	308,616	22,855,538	0.013503	702	9	55.00
60.00	06000	LABORATORY	397,129	68,511,021	0.005797	1,206,747	6,996	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	240,982	14,920,013	0.016152	1,218,453	19,680	65.00
66.00	06600	PHYSICAL THERAPY	854,880	25,632,051	0.033352	8,235,922	274,684	66.00
69.00	06900	ELECTROCARDIOLOGY	717,388	36,510,527	0.019649	92,471	1,817	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	285,653	5,621,354	0.050816	7,371	375	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,902	7,863,443	0.019572	169,576	3,319	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	159,435	14,169,547	0.011252	9,557	108	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	329,482	81,064,615	0.004064	1,563,468	6,354	73.00
75.00	07500	ASC (NON-DISTINCT PART)	93,538	20,639,902	0.004532	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	306,144	1,432,189	0.213759	101,189	21,630	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	101,558	159,344	0.637351	0	0	90.00
90.01	04950	WOUND CLINIC	130,097	7,385,810	0.017614	9	0	90.01
91.00	09100	EMERGENCY	857,496	52,809,489	0.016238	8,069	131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,839,950	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	16,478	560,220	0.029413	0	0	96.00
200.00		Total (lines 50 through 199)	7,544,455	519,331,616		13,080,986	341,766	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	269,846	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	291,989	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	561,835	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	41,472,705	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	11,605,653	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,340,753	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	269,846	269,846	92,937,492	0.002904	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	22,855,538	0.000000	55.00
60.00	06000	LABORATORY	0	291,989	291,989	68,511,021	0.004262	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,920,013	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,632,051	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,510,527	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,621,354	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,863,443	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,169,547	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	81,064,615	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	20,639,902	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,432,189	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	159,344	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	7,385,810	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	52,809,489	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,839,950	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	560,220	0.000000	96.00
200.00		Total (lines 50 through 199)	0	561,835	561,835	519,331,616		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	10,943	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	6,107	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	453	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.002904	449,949	1,307	14,145	41	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	702	0	0	0	55.00
60.00	06000	LABORATORY	0.004262	1,206,747	5,143	2,318	10	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,218,453	0	14	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	8,235,922	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	92,471	0	288	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	7,371	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	169,576	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	9,557	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,563,468	0	301	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	101,189	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	1	0	90.00
90.01	04950	WOUND CLINIC	0.000000	9	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	8,069	0	1,037	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		13,080,986	6,450	18,104	51	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.170813	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.251647	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.332956	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114685	14,145	0	0	1,622	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.169551	0	0	0	0	55.00
60.00	06000	LABORATORY	0.142156	2,318	0	0	330	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.244900	14	0	0	3	65.00
66.00	06600	PHYSICAL THERAPY	0.278352	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.174712	288	0	0	50	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233144	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.087566	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461914	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272051	301	0	1,392	82	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.178339	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.575365	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.251475	1	0	0	2	90.00
90.01	04950	WOUND CLINIC	0.273555	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.187685	1,037	0	0	195	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503619	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.362258	0	0	0	0	96.00
200.00		Subtotal (see instructions)		18,104	0	1,392	2,284	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		18,104	0	1,392	2,284	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	0	0		51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	379		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	379		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	379		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 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)	17,158	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,158	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)	12,998	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)	8,314	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)	14,207,884	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)	14,207,884	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)	14,207,884	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)	828.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,884,491	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)	6,884,491	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,383,992	7,149	1,172.75	4,530	5,312,558	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	19,268,071	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	31,465,120	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)	2,105,469	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,519,546	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,625,015	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	27,840,105	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	4,160	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	828.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,444,730	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,863,799	14,207,884	0.201564	3,444,730	694,334	90.00
91.00	Nursing School cost	0	14,207,884	0.000000	3,444,730	0	91.00
92.00	Allied health cost	0	14,207,884	0.000000	3,444,730	0	92.00
93.00	All other Medical Education	0	14,207,884	0.000000	3,444,730	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 1/20/2020 10:18 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)	4,410	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,410	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,410	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)	1,645	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)	4,865,398	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)	4,865,398	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)	4,865,398	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)	1,103.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,814,863	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,814,863	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	166,011	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,980,874	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)	231,303	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,870	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	238,173	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,742,701	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 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	620,077	4,865,398	0.127446	0	0	90.00
91.00	Nursing School cost	0	4,865,398	0.000000	0	0	91.00
92.00	Allied health cost	0	4,865,398	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,865,398	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 1/20/2020 10:18 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,324	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,324	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,324	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,323	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)	4,421,498	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)	4,421,498	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)	4,421,498	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)	603.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,817,195	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)	3,817,195	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,510,027	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,327,222	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)	621,361	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	348,216	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	969,577	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,357,645	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	719,722	4,421,498	0.162778	0	0	90.00
91.00	Nursing School cost	0	4,421,498	0.000000	0	0	91.00
92.00	Allied health cost	0	4,421,498	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,421,498	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 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)	17,158	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,158	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)	12,998	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)	232	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)	995	15.00
16.00	Nursery days (title V or XIX only)	43	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)	14,207,884	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)	14,207,884	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)	14,207,884	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)	828.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	192,110	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)	192,110	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 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)	608,587	995	611.65	43	26,301	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,383,992	7,149	1,172.75	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)	301,715	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	520,126	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)	4,160	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	828.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,444,730	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 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	2,863,799	14,207,884	0.201564	3,444,730	694,334	90.00
91.00	Nursing School cost	0	14,207,884	0.000000	3,444,730	0	91.00
92.00	Allied health cost	0	14,207,884	0.000000	3,444,730	0	92.00
93.00	All other Medical Education	0	14,207,884	0.000000	3,444,730	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 1/20/2020 10:18 am
	Title XIX	Subprovider - IPF	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)	4,410	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,410	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,410	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)	179	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)	995	15.00
16.00	Nursery days (title V or XIX only)	43	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)	4,865,398	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)	4,865,398	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)	4,865,398	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)	1,103.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	197,484	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)	197,484	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	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)	17,055	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	214,539	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/20/2020 10:18 am

Title XIX | Subprovider - IPF | 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	620,077	4,865,398	0.127446	0	0	90.00
91.00	Nursing School cost	0	4,865,398	0.000000	0	0	91.00
92.00	Allied health cost	0	4,865,398	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,865,398	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/20/2020 10:18 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		15,332,458		30.00
31.00	03100	INTENSIVE CARE UNIT		11,095,578		31.00
40.00	04000	SUBPROVIDER - IPF		6,262		40.00
41.00	04100	SUBPROVIDER - IRF		138,054		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170813	11,061,820	1,889,503	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.251647	936,648	235,705	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.332956	3,697	1,231	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114685	9,812,380	1,125,333	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.170248	244,548	41,634	55.00
60.00	06000	LABORATORY	0.142156	12,893,811	1,832,933	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.244900	6,273,199	1,536,306	65.00
66.00	06600	PHYSICAL THERAPY	0.278352	3,984,960	1,109,222	66.00
69.00	06900	ELECTROCARDIOLOGY	0.175723	8,414,658	1,478,649	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.235153	45,819	10,774	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.087566	2,200,771	2,393,484	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461914	4,721,754	2,181,044	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272051	11,391,050	3,098,947	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.178492	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.579439	1,000,921	579,973	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.251475	0	0	90.00
90.01	04950	WOUND CLINIC	0.273555	25,305	6,922	90.01
91.00	09100	EMERGENCY	0.188136	6,384,619	1,201,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503619	1,082,631	545,234	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.362258	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		80,478,591	19,268,071	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)		80,478,591		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/20/2020 10:18 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		6,600		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,613,400		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170813	1,254	214	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.251647	1,507	379	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.332956	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114685	32,897	3,773	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.170248	0	0	55.00
60.00	06000	LABORATORY	0.142156	86,290	12,267	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.244900	185,098	45,331	65.00
66.00	06600	PHYSICAL THERAPY	0.278352	19,845	5,524	66.00
69.00	06900	ELECTROCARDIOLOGY	0.175723	6,546	1,150	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.235153	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.087566	2,846	3,095	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461914	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272051	340,229	92,560	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.178492	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.579439	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.251475	0	0	90.00
90.01	04950	WOUND CLINIC	0.273555	0	0	90.01
91.00	09100	EMERGENCY	0.188136	9,130	1,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503619	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.362258	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		685,642	166,011	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)		685,642		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		540,605		30.00
31.00	03100	INTENSIVE CARE UNIT		48,596		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		6,216,981		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170813	10,943	1,869	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.251647	6,107	1,537	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.332956	453	151	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114685	449,949	51,602	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.170248	702	120	55.00
60.00	06000	LABORATORY	0.142156	1,206,747	171,546	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.244900	1,218,453	298,399	65.00
66.00	06600	PHYSICAL THERAPY	0.278352	8,235,922	2,292,485	66.00
69.00	06900	ELECTROCARDIOLOGY	0.175723	92,471	16,249	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.235153	7,371	1,733	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.087566	169,576	184,425	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461914	9,557	4,415	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272051	1,563,468	425,343	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.178492	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.579439	101,189	58,633	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.251475	0	0	90.00
90.01	04950	WOUND CLINIC	0.273555	9	2	90.01
91.00	09100	EMERGENCY	0.188136	8,069	1,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503619	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.362258	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,080,986	3,510,027	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)		13,080,986		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/20/2020 10:18 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		211,944		30.00
31.00	03100	INTENSIVE CARE UNIT		140,226		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		69,926		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170813	190,132	32,477	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.251647	14,638	3,684	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.332956	207,168	68,978	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114685	159,112	18,248	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.169551	685	116	55.00
60.00	06000	LABORATORY	0.142156	234,504	33,336	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.244900	98,703	24,172	65.00
66.00	06600	PHYSICAL THERAPY	0.278352	41,750	11,621	66.00
69.00	06900	ELECTROCARDIOLOGY	0.174712	98,940	17,286	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233144	1,046	244	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.087566	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461914	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272051	215,299	58,572	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.178339	4,264	760	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.575365	2,472	1,422	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.251475	0	0	90.00
90.01	04950	WOUND CLINIC	0.273555	288	79	90.01
91.00	09100	EMERGENCY	0.187685	149,314	28,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503619	5,354	2,696	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.362258	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,423,669	301,715	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)		1,423,669		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/20/2020 10:18 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		356,953		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.170813	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	0.251647	129	32	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.332956	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114685	10,476	1,201	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.169551	0	0	55.00
60.00	06000	LABORATORY	0.142156	23,589	3,353	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.244900	6,600	1,616	65.00
66.00	06600	PHYSICAL THERAPY	0.278352	5,777	1,608	66.00
69.00	06900	ELECTROCARDIOLOGY	0.174712	1,742	304	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.233144	510	119	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.087566	1,209	1,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461914	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272051	26,607	7,238	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.178339	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.575365	468	269	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.251475	0	0	90.00
90.01	04950	WOUND CLINIC	0.273555	0	0	90.01
91.00	09100	EMERGENCY	0.187685	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.503619	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.362258	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		77,107	17,055	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)		77,107		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 1/20/2020 10:18 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)	18,339,364	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,348,587	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)	292,942	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)	85.74	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 that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.53	30.00
31.00	Percentage of Medicaid patient days (see instructions)	13.31	31.00
32.00	Sum of lines 30 and 31	17.84	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.35	33.00
34.00	Disproportionate share adjustment (see instructions)	257,607	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 1/20/2020 10:18 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)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000195298	0.000269449	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,321,520	2,229,117	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	988,424	561,860	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,550,284		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)	25,788,784		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)	25,788,784	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,958,836	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	10,014	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)	83,448	58.00
59.00	Total (sum of amounts on lines 49 through 58)	27,841,082	59.00
60.00	Primary payer payments	7,445	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	27,833,637	61.00
62.00	Deductibles billed to program beneficiaries	2,787,820	62.00
63.00	Coinsurance billed to program beneficiaries	63,620	63.00
64.00	Allowable bad debts (see instructions)	192,417	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	125,071	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	91,496	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	25,107,268	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	81,498	70.93
70.94	HRR adjustment amount (see instructions)	-85,964	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 1/20/2020 10:18 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)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		277,431	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		24,825,371	71.00
71.01	Sequestration adjustment (see instructions)		496,507	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		24,331,705	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-2,841	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		392,591	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (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)	0.00000000000	0.00000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/20/2020 10:18 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	18,339,364	0	18,339,364		18,339,364	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,348,587	0		5,348,587	5,348,587	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	292,942	0	201,496	91,446	292,942	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	0.0435	0.0435	0.0435	0.0435		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	257,607	0	199,441	58,166	257,607	11.00
11.01	Uncompensated care payments	36.00	1,550,284	0	988,424	561,860	1,550,284	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	25,788,784	0	19,728,725	6,060,059	25,788,784	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	25,788,784	0	19,728,725	6,060,059	25,788,784	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,958,836	0	1,514,637	444,199	1,958,836	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: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/20/2020 10:18 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	21,243,362	6,504,258	27,747,620	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,910,545	0	1,480,308	430,237	1,910,545	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	48,291	0	34,329	13,962	48,291	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,958,836	0	1,514,637	444,199	1,958,836	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	18,339,364	18,339,364		18,339,364	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,348,587		5,348,587	5,348,587	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	292,942	201,496	91,446	292,942	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	0.0435	0.0435	0.0435		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	257,607	199,441	58,166	257,607	11.00
11.01	Uncompensated care payments	36.00	1,550,284	988,424	561,860	1,550,284	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	25,788,784	19,728,725	6,060,059	25,788,784	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	25,788,784	19,728,725	6,060,059	25,788,784	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,958,836	1,514,637	444,199	1,958,836	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			21,243,362	6,504,258	27,747,620	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/20/2020 10:18 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	1,910,545	1,480,308	430,237	1,910,545	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	48,291	34,329	13,962	48,291	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,958,836	1,514,637	444,199	1,958,836	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	81,498	78,177	3,321	81,498	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	-85,964	-71,523	-14,441	-85,964	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		212,500	64,931	277,431	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 1/20/2020 10:18 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12,009	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	29,321,967	2.00
3.00	OPPS payments	26,490,932	3.00
4.00	Outlier payment (see instructions)	121,531	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	121,331	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	12,009	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	44,186	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)	44,186	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)	44,186	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	32,177	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	12,009	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	26,733,794	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,213,235	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)	21,532,568	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)	21,532,568	30.00
31.00	Primary payer payments	1,552	31.00
32.00	Subtotal (line 30 minus line 31)	21,531,016	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)	717,410	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	466,317	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	523,728	36.00
37.00	Subtotal (see instructions)	21,997,333	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-69	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	2,600	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	21,997,402	40.00
40.01	Sequestration adjustment (see instructions)	439,948	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	21,363,847	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	193,607	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 1/20/2020 10:18 am
Component CCN: 15-S042		
Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	99	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	177	2.00
3.00	OPPS payments	456	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	99	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	364	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)	364	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)	364	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	265	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	99	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	456	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	555	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)	555	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	555	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	555	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	555	40.00
40.01	Sequestration adjustment (see instructions)	11	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	553	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-9	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 1/20/2020 10:18 am
Component CCN: 15-T042		
Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	379	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,233	2.00
3.00	OPPS payments	1,485	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	51	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	379	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,392	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	1,392	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,392	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,013	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	379	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	1,536	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	193	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,722	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,722	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,722	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,722	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,722	40.00
40.01	Sequestration adjustment (see instructions)	34	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,673	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	15	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 1/20/2020 10:18 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		24,207,452		20,975,367	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	12/31/2018	197,112	12/31/2018	456,499	3.01
3.02			0	07/16/2018	29,200	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	12/31/2018	72,859	12/31/2018	97,219	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)		124,253		388,480	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)		24,331,705		21,363,847	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		193,607	6.01
6.02	SETTLEMENT TO PROGRAM		2,841		0	6.02
7.00	Total Medicare program liability (see instructions)		24,328,864		21,557,454	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0042 | Component CCN: 15-S042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 1/20/2020 10:18 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		1,107,333		553	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	12/31/2018	488		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)		488		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,107,821		553	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		7,056		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		9	6.02
7.00	Total Medicare program liability (see instructions)		1,114,877		544	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0042 | Component CCN: 15-T042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 1/20/2020 10:18 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,032,966		1,682	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	12/31/2018	76,027	12/31/2018	9	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)		-76,027		-9	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)		8,956,939		1,673	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		20,181		15	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,977,120		1,688	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 1/20/2020 10:18 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		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 1/20/2020 10:18 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)	1,374,457	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	12.082192	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,374,457	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,374,457	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,374,457	18.00
19.00	Deductibles	172,812	19.00
20.00	Subtotal (line 18 minus line 19)	1,201,645	20.00
21.00	Coinsurance	71,690	21.00
22.00	Subtotal (line 20 minus line 21)	1,129,955	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11,094	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	7,211	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,194	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,137,166	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)	464	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,137,630	31.00
31.01	Sequestration adjustment (see instructions)	22,753	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,107,821	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	7,056	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 1/20/2020 10:18 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	8,913,465	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0209	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	111,418	3.00
4.00	Outlier Payments	240,019	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	20.065753	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	9,264,902	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	9,264,902	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	9,264,902	19.00
20.00	Deductibles	112,347	20.00
21.00	Subtotal (line 19 minus line 20)	9,152,555	21.00
22.00	Coinsurance	19,765	22.00
23.00	Subtotal (line 21 minus line 22)	9,132,790	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	32,441	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	21,087	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,609	26.00
27.00	Subtotal (sum of lines 23 and 25)	9,153,877	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	6,450	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	9,160,327	32.00
32.01	Sequestration adjustment (see instructions)	183,207	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	8,956,939	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	20,181	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	240,019	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part VII Date/Time Prepared: 1/20/2020 10:18 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	520,126		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)	520,126	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)	520,126	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	422,097		8.00
9.00	Ancillary service charges	1,423,669	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)	1,845,766	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)	1,845,766	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,325,640	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)	520,126	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)	520,126	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)	520,126	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)	520,126	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	520,126	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)	520,126	0	40.00
41.00	Interim payments	845,933	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-325,807	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 1/20/2020 10:18 am
	Title XIX	Subprovider - IPF	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	214,539		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)	214,539	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)	214,539	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	356,953		8.00
9.00	Ancillary service charges	77,107	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)	434,060	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)	434,060	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	219,521	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)	214,539	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)	214,539	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)	214,539	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)	214,539	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	214,539	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)	214,539	0	40.00
41.00	Interim payments	170,343	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	44,196	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 1/20/2020 10:18 am
	Title XIX	Subprovider - IRF	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	0		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)	0	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)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	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)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	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)	0	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)	0	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)	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 1/20/2020 10:18 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	26,116,732	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	86,803,328	0	0	0	4.00
5.00	Other receivable	3,567,372	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-52,969,989	0	0	0	6.00
7.00	Inventory	2,262,980	0	0	0	7.00
8.00	Prepaid expenses	3,999,245	0	0	0	8.00
9.00	Other current assets	96,036	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)	69,875,704	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,781,448	0	0	0	12.00
13.00	Land improvements	4,687,184	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	161,037,809	0	0	0	15.00
16.00	Accumulated depreciation	-66,349,557	0	0	0	16.00
17.00	Leasehold improvements	862,950	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	217,206,153	0	0	0	23.00
24.00	Accumulated depreciation	-136,563,781	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)	187,662,206	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	41,857,447	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	735,598	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	42,593,045	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	300,130,955	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,250,041	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,533,090	0	0	0	38.00
39.00	Payroll taxes payable	11,003,946	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,567,666	0	0	0	40.00
41.00	Deferred income	1,127,801	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	1,816,618	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,299,162	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	111,984,227	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)	111,984,227	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	134,283,389	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	165,847,566				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)	165,847,566	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	300,130,955	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 1/20/2020 10:18 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		177,301,758		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-11,454,191				2.00
3.00	Total (sum of line 1 and line 2)		165,847,567		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)		165,847,567		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)		165,847,567		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/20/2020 10:18 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	27,952,694		27,952,694	1.00
2.00	SUBPROVIDER - IPF	8,036,814		8,036,814	2.00
3.00	SUBPROVIDER - IRF	7,995,044		7,995,044	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)	43,984,552		43,984,552	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	18,525,338		18,525,338	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	18,525,338		18,525,338	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	62,509,890		62,509,890	17.00
18.00	Ancillary services	144,460,402	307,116,399	451,576,801	18.00
19.00	Outpatient services	12,555,595	54,638,999	67,194,594	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	4,994	3,507,651	3,512,645	26.00
27.00	COMMUNITY MENTAL HEALTH CENTER	99,262	9,545,475	9,644,737	27.00
27.01	DME	0	560,220	560,220	27.01
27.02	MH RESIDENTIAL	0	236,110	236,110	27.02
27.03	PHYSICIAN FEES	8,110,301	66,014,669	74,124,970	27.03
27.04	PROFESSIONAL FEES	0	10,230,635	10,230,635	27.04
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	227,740,444	451,850,158	679,590,602	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		245,338,300		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)		245,338,300		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0042 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 1/20/2020 10:18 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	679,590,602	1.00
2.00	Less contractual allowances and discounts on patients' accounts	455,968,611	2.00
3.00	Net patient revenues (line 1 minus line 2)	223,621,991	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	245,338,300	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-21,716,309	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	3,543,983	23.00
24.00	OTHER REVENUE	2,952,973	24.00
24.01	INVESTMENT INCOME	-755,757	24.01
24.02	INTEREST EXPENSE	0	24.02
24.03	OTHER NONOPERATING	1,072,643	24.03
24.04	INTERCOMPANY TRANSFERS	2,825,013	24.04
24.05	DIETARY REVENUE	622,663	24.05
24.06	PSYCH REVENUE	0	24.06
24.07	ADMIN	600	24.07
25.00	Total other income (sum of lines 6-24)	10,262,118	25.00
26.00	Total (line 5 plus line 25)	-11,454,191	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-11,454,191	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O | Date/Time Prepared: 1/20/2020 10:18 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	130,304	559,947	690,251	-156,841	533,410	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	3,580	3,580	0	3,580	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	3,659	3,659	0	3,659	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	432	432	0	432	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	13,846	3,976	17,822	0	17,822	26.00
27.00	NURSE PRACTITIONER**	291	84	375	0	375	27.00
28.00	REGISTERED NURSE**	181,354	52,087	233,441	0	233,441	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**	87,320	25,080	112,400	0	112,400	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	59,922	17,210	77,132	0	77,132	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	57,989	16,656	74,645	0	74,645	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	531,026	682,711	1,213,737	-156,841	1,056,896	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O | Date/Time Prepared: 1/20/2020 10:18 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*	-66	533,344		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	3,580		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	3,659		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	432		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	17,822		26.00
27.00	NURSE PRACTITIONER**	0	375		27.00
28.00	REGISTERED NURSE**	0	233,441		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	112,400		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	77,132		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	74,645		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	-66	1,056,830		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: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-2 | Date/Time Prepared: 1/20/2020 10:18 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	12,743	3,660	16,403	0	16,403	26.00
27.00	NURSE PRACTITIONER	268	77	345	0	345	27.00
28.00	REGISTERED NURSE	166,908	47,938	214,846	0	214,846	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	80,365	23,082	103,447	0	103,447	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	55,148	15,839	70,987	0	70,987	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	53,370	15,329	68,699	0	68,699	46.00
100.00	TOTAL *	368,802	105,925	474,727	0	474,727	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	16,403		26.00
27.00	NURSE PRACTITIONER	0	345		27.00
28.00	REGISTERED NURSE	0	214,846		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	103,447		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	70,987		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	68,699		46.00
100.00	TOTAL *	0	474,727		100.00

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

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

Provider CCN: 15-0042 Hospice CCN: 15-1526 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-3 Date/Time Prepared: 1/20/2020 10:18 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	25.00
26.00	PHYSICIAN SERVICES	102	29	131	0	131	26.00
27.00	NURSE PRACTITIONER	2	1	3	0	3	27.00
28.00	REGISTERED NURSE	1,336	384	1,720	0	1,720	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	643	185	828	0	828	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	442	127	569	0	569	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	427	123	550	0	550	46.00
100.00	TOTAL *	2,952	849	3,801	0	3,801	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	131		26.00
27.00	NURSE PRACTITIONER	0	3		27.00
28.00	REGISTERED NURSE	0	1,720		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	828		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	569		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	550		46.00
100.00	TOTAL *	0	3,801		100.00

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

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

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-4 | Date/Time Prepared: 1/20/2020 10:18 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	25.00
26.00	PHYSICIAN SERVICES	1,001	287	1,288	0	1,288	26.00
27.00	NURSE PRACTITIONER	21	6	27	0	27	27.00
28.00	REGISTERED NURSE	13,110	3,765	16,875	0	16,875	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	6,312	1,813	8,125	0	8,125	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	4,332	1,244	5,576	0	5,576	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	4,192	1,204	5,396	0	5,396	46.00
100.00	TOTAL *	28,968	8,319	37,287	0	37,287	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	1,288		26.00
27.00	NURSE PRACTITIONER	0	27		27.00
28.00	REGISTERED NURSE	0	16,875		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	8,125		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	5,576		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	5,396		46.00
100.00	TOTAL *	0	37,287		100.00

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

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

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

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

Worksheet O-5

Date/Time Prepared: 1/20/2020 10:18 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	116,419	116,419	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	100	100	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	187,577	187,577	3.00
4.00	ADMINISTRATIVE & GENERAL	533,344	166,162	699,506	4.00
5.00	PLANT OPERATION & MAINTENANCE	3,580	68,482	72,062	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	46,641	46,641	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	70,576	70,576	9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,659	701	4,360	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	432	128	560	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	474,727		474,727	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,801		3,801	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	37,287		37,287	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	1,056,830	656,786	1,713,616	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part I | Date/Time Prepared: 1/20/2020 10:18 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	116,419	116,419				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	100		100			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	187,577	0	0	187,577		3.00
4.00	ADMINISTRATIVE & GENERAL	699,506	0	0	0	699,506	4.00
5.00	PLANT OPERATION & MAINTENANCE	72,062	0	0	0	72,062	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	46,641	0	0	0	46,641	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	70,576	0	0	0	70,576	9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,360	0	0	0	4,360	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	560	0	0	0	560	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	474,727			172,634	647,361	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,801	11,540	10	1,383	16,734	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	37,287	104,879	90	13,560	155,816	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,713,616	116,419	100	187,577	1,713,616	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

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

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

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	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	699,506					4.00
5.00	PLANT OPERATION & MAINTENANCE	49,706	121,768				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	32,172	0		78,813		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	48,681	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,007	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	386	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	446,533					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	11,543	12,070	0	7,812	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	107,478	109,698	0	71,001	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	699,506	121,768	0	78,813	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part I | Date/Time Prepared: 1/20/2020 10:18 am

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	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	119,257					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	7,367				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	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	109,757	6,781	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	879	54	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	8,621	532	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	119,257	7,367	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

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

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

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	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	946					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	870	0	0		1,211,302	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7	0	0	0	49,099	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	69	0	0	0	453,215	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	946	0	0	0	1,713,616	100.00

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

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

Period:
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	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	686					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		686				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	209,613			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-699,506	1,014,110	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	72,062	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	46,641	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	70,576	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	4,360	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	560	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			192,915	0	647,361	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	68	68	1,545	0	16,734	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	618	618	15,153	0	155,816	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)	116,419	100	187,577		699,506	100.00
101.00	UNIT COST MULTIPLIER	169.706997	0.145773	0.894873		0.689773	101.00

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

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

Period:
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	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	686					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		686			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		127,948	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					117,756	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	68	0	68	0	943	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	618	0	618	0	9,249	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)	121,768	0	78,813	0	119,257	100.00
101.00	UNIT COST MULTIPLIER	177.504373	0.000000	114.887755	0.000000	0.932074	101.00

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

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

Period:
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	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	8,614					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	1,269	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	7,929	0	0	0	1,168	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	63	0	0	0	9	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	622	0	0	0	92	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)	7,367	0	0	0	946	100.00
101.00	UNIT COST MULTIPLIER	0.855236	0.000000	0.000000	0.000000	0.745469	101.00

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

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

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

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

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

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

Worksheet O-7

Date/Time Prepared: 1/20/2020 10:18 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	0.278352	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.272051	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.362258	0	0	0	5.00
6.00	LABORATORY	60.00	0.142156	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1.087566	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.169551	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	76.00	0.000000	0	0	0	10.00
10.01	INPATIENT DIALYSIS	76.01	0.575365	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0042 | Hospice CCN: 15-1526 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-8 | Date/Time Prepared: 1/20/2020 10:18 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)			1,211,302	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			7,929	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			152.77	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	6,873	124		9.00
10.00	Program cost (line 8 times line 9)	1,049,988	18,943		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)			49,099	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			63	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			779.35	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	32	7		14.00
15.00	Program cost (line 13 times line 14)	24,939	5,455		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)			453,215	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			622	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			728.64	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	514	15		19.00
20.00	Program cost (line 18 times line 19)	374,521	10,930		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,713,616	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			8,614	22.00
23.00	Average cost per diem (line 21 divided by line 22)			198.93	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 1/20/2020 10:18 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,910,545	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	48,291	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)	55.47	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,958,836	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