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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 9:57 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 9:57 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 HANCOCK REGIONAL HOSPITAL (15-0037) 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		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	158,936	-101,427	0	-119,433	1.00
2.00	Subprovider - IPF	0	526	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		11,745		0	10.00
200.00	Total	0	159,462	-89,682	0	-119,433	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 9:57 am

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

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

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	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	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 9:57 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	
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.	98	827	0	0	479	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			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)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 9:57 am

		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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						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: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 9:57 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.	N			75.00
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.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 9:57 am

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

		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	813,499	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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	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)	10/01/2016	12/31/2016	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 9:57 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/05/2019	Y	03/05/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 9:57 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

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

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

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

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	37	13,505	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		37	13,505	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		61	22,265	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	7	2,555			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		78				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 9:57 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,156	51	3,441			1.00
2.00	HMO and other (see instructions)	0	1,284				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,156	51	3,441			7.00
8.00	INTENSIVE CARE UNIT	1,868	46	4,759			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,024	97	8,200	0.00	608.51	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,003	0	2,466	0.00	17.33	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	954	0.00	17.46	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	243	0	3,204	0.00	4.35	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	647.65	27.00
28.00	Observation Bed Days		0	1,731			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			65			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	23	50			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

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	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	946	24	2,388	1.00
2.00	HMO and other (see instructions)			0	210		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	946	24	2,388	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	176	0	246	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2019 9:57 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	47,531,924	0	47,531,924	1,344,562.00	35.35	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,509,573	0	1,509,573	10,064.00	150.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		229,149	0	229,149	8,871.00	25.83	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		7,547,681	164,977	7,712,658	203,987.82	37.81	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		201,980	0	201,980	3,230.85	62.52	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		176,055	0	176,055	1,610.06	109.35	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)		8,982,929	0	8,982,929			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		383,407	0	383,407			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		9,503	0	9,503			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		139,002	0	139,002			23.00
24.00	Wage-related costs (RHC/FQHC)		54,163	0	54,163			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
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	533,672	0	533,672	12,938.74	41.25	26.00
27.00	Administrative & General	5.00	8,983,716	-164,977	8,818,739	220,661.75	39.96	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2019 9:57 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	
28.00	Administrative & General under contract (see inst.)		980,007	0	980,007	6,881.24	142.42	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,055,841	0	1,055,841	34,609.81	30.51	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,422,043	0	1,422,043	84,059.32	16.92	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,429,180	-989,487	439,693	23,595.32	18.63	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	989,487	989,487	53,097.00	18.64	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,218,229	0	1,218,229	27,145.61	44.88	38.00
39.00	Central Services and Supply	14.00	57,007	0	57,007	2,415.78	23.60	39.00
40.00	Pharmacy	15.00	1,852,368	-27,751	1,824,617	40,483.67	45.07	40.00
41.00	Medical Records & Medical Records Library	16.00	606,304	0	606,304	23,639.22	25.65	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2019 9:57 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)		46,773,209	0	46,773,209	1,332,508.24	35.10	1.00
2.00	Excluded area salaries (see instructions)		7,547,681	164,977	7,712,658	203,987.82	37.81	2.00
3.00	Subtotal salaries (line 1 minus line 2)		39,225,528	-164,977	39,060,551	1,128,520.42	34.61	3.00
4.00	Subtotal other wages & related costs (see inst.)		378,035	0	378,035	4,840.91	78.09	4.00
5.00	Subtotal wage-related costs (see inst.)		8,982,929	0	8,982,929	0.00	23.00	5.00
6.00	Total (sum of lines 3 thru 5)		48,586,492	-164,977	48,421,515	1,133,361.33	42.72	6.00
7.00	Total overhead cost (see instructions)		18,138,367	-192,728	17,945,639	529,527.46	33.89	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2019 9:57 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,710,452	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	3,675,598	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)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	517,048	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	154,892	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)	105,785	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,646	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	3,293,256	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	8,831	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	33,589	22.00
23.00	Tuition Reimbursement	67,906	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,569,003	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/29/2019 9:57 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	201,980	9,569,003	1.00
2.00	Hospital	201,980	9,569,003	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 9:57 am

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	224 WEST MAIN STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	KNIGHTSTOWN	IN	46148	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	137632	07/01/2015	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

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

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

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

		County	
		4.00	
2.00	City, State, ZIP Code, County	HENRY	2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2018 To 12/31/2018	Worksheet S-8 Date/Time Prepared: 5/29/2019 9:57 am
		RHC I	Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

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

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

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
5/29/2019 9:57 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	1,243	0	0	1,243	11.00
12.00	Hospice Inpatient Respite Care	60	0	0	60	12.00
13.00	Hospice General Inpatient Care	93	0	0	93	13.00
14.00	Total Hospice Days	1,396	0	0	1,396	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 9:57 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)	0.249418	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,240,681	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	37,673,181	6.00
7.00	Medicaid cost (line 1 times line 6)	9,396,369	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)	3,155,688	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)	3,155,688	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)	3,144,957	1,895,118	5,040,075	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	784,409	1,895,118	2,679,527	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)	784,409	1,895,118	2,679,527	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)	12,281,865	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	0	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	0	27.01
28.00	Non-Medicare bad debt expense (see instructions)	12,281,865	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,063,318	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,742,845	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,898,533	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		10,292,324	10,292,324	0	10,292,324	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	533,672	6,859,907	7,393,579	0	7,393,579	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,983,716	15,932,347	24,916,063	-1,012,920	23,903,143	5.00
7.00	00700	OPERATION OF PLANT	1,055,841	5,238,755	6,294,596	1,603	6,296,199	7.00
9.00	00900	HOUSEKEEPING	1,422,043	849,777	2,271,820	0	2,271,820	9.00
10.00	01000	DIETARY	1,429,180	1,174,653	2,603,833	-1,802,753	801,080	10.00
11.00	01100	CAFETERIA	0	0	0	1,802,753	1,802,753	11.00
13.00	01300	NURSING ADMINISTRATION	1,218,229	315,716	1,533,945	0	1,533,945	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,007	49,541	106,548	-81	106,467	14.00
15.00	01500	PHARMACY	1,852,368	12,507,690	14,360,058	-11,735,374	2,624,684	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	606,304	210,541	816,845	5,210	822,055	16.00
23.00	02300	PARAMED ED PRGM	121,555	18,977	140,532	-2,184	138,348	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,811,780	685,104	3,496,884	-12,509	3,484,375	30.00
31.00	03100	INTENSIVE CARE UNIT	3,179,078	701,573	3,880,651	-22,899	3,857,752	31.00
40.00	04000	SUBPROVIDER - IPF	1,221,718	239,240	1,460,958	-474	1,460,484	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,179,952	3,091,898	6,271,850	-50,561	6,221,289	50.00
51.00	05100	RECOVERY ROOM	320,969	38,803	359,772	-1,209	358,563	51.00
53.00	05300	ANESTHESIOLOGY	0	137,470	137,470	0	137,470	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,143,350	1,982,221	5,125,571	-299,042	4,826,529	54.00
60.00	06000	LABORATORY	1,588,872	2,652,479	4,241,351	5,738	4,247,089	60.00
65.00	06500	RESPIRATORY THERAPY	1,385,872	218,786	1,604,658	3,173	1,607,831	65.00
66.00	06600	PHYSICAL THERAPY	1,128,098	112,495	1,240,593	-555	1,240,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	326,741	25,318	352,059	0	352,059	67.00
68.00	06800	SPEECH PATHOLOGY	168,924	17,089	186,013	0	186,013	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	630,279	302,696	932,975	14,078	947,053	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,579,721	3,579,721	0	3,579,721	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,459,164	1,459,164	0	1,459,164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,352,652	12,352,652	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	63,782	6,734	70,516	-15	70,501	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	229,149	211,347	440,496	-28,988	411,508	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	498,846	245,932	744,778	-9,861	734,917	90.01
90.02	09002	DIABETES CLINIC	49,606	8,092	57,698	0	57,698	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	121,691	36,196	157,887	-5	157,882	90.04
90.05	09005	PRIME TIME	0	119,621	119,621	0	119,621	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	223,854	133,209	357,063	-5,136	351,927	90.06
90.07	04951	ONCOLOGY	915,742	1,095,939	2,011,681	-21,473	1,990,208	90.07
90.08	04950	ANDERSON WOMENS CENTER	320,720	27,247	347,967	-115	347,852	90.08
91.00	09100	EMERGENCY	2,538,578	619,376	3,157,954	-33,941	3,124,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,309,460	1,031,541	2,341,001	-140,889	2,200,112	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,636,976	72,229,519	114,866,495	-995,777	113,870,718	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	65	339,083	339,148	-15,342	323,806	190.01
190.02	19002	PHYSICIAN BUILDING	0	8,987	8,987	0	8,987	190.02
190.03	19003	PRIVATE DUTY	550,261	554,014	1,104,275	0	1,104,275	190.03
190.04	19004	MARKETING	0	0	0	1,012,920	1,012,920	190.04
190.05	19005	SPORTS PHYSICALS	56,681	4,910	61,591	0	61,591	190.05
190.06	19006	FOUNDATION	185,464	1,160,451	1,345,915	0	1,345,915	190.06
190.07	19007	ASC	0	7,725	7,725	-528	7,197	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	57,783	57,783	0	57,783	190.08
190.09	19009	HANCOCK OB	1,612,198	4,998,757	6,610,955	-13	6,610,942	190.09
190.10	19010	HANCOCK WELLNESS	789,648	313,505	1,103,153	0	1,103,153	190.10
190.11	19011	MORRISTOWN CLINIC	0	1,800	1,800	0	1,800	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	603,616	251,199	854,815	0	854,815	190.13
190.14	19014	3 WEST UNIT	189,128	205,277	394,405	-90	394,315	190.14
190.15	19015	NEUROLOGY PHYSICIAN	594,060	417,104	1,011,164	0	1,011,164	190.15
190.16	19016	THORACI	0	193,165	193,165	0	193,165	190.16
190.17	19017	HANCOCK ENDO	0	108,241	108,241	0	108,241	190.17

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A Date/Time Prepared: 5/29/2019 9:57 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	
190.18	19018	HANCOCK FOOT & ANKLE	313,827	142,818	456,645	-1,170	455,475	190.18
190.19	19019	HANCOCK RHEUM	0	84,982	84,982	0	84,982	190.19
200.00		TOTAL (SUM OF LINES 118 through 199)	47,531,924	81,079,320	128,611,244	0	128,611,244	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-506,918	9,785,406	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,426,560	4,967,019	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,155,780	15,747,363	5.00
7.00	00700	OPERATION OF PLANT	-18,807	6,277,392	7.00
9.00	00900	HOUSEKEEPING	-159,292	2,112,528	9.00
10.00	01000	DIETARY	-447,077	354,003	10.00
11.00	01100	CAFETERIA	-138,207	1,664,546	11.00
13.00	01300	NURSING ADMINISTRATION	-19,960	1,513,985	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-32,590	73,877	14.00
15.00	01500	PHARMACY	-979,527	1,645,157	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-57,100	764,955	16.00
23.00	02300	PARAMED ED PRGM	-45,560	92,788	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-51,392	3,432,983	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,857,752	31.00
40.00	04000	SUBPROVIDER - IPF	-96,000	1,364,484	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-1,280,767	4,940,522	50.00
51.00	05100	RECOVERY ROOM	0	358,563	51.00
53.00	05300	ANESTHESIOLOGY	-136,948	522	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-37,733	4,788,796	54.00
60.00	06000	LABORATORY	-224,838	4,022,251	60.00
65.00	06500	RESPIRATORY THERAPY	-90,479	1,517,352	65.00
66.00	06600	PHYSICAL THERAPY	0	1,240,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	352,059	67.00
68.00	06800	SPEECH PATHOLOGY	0	186,013	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	-6,100	940,953	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-81	3,579,640	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,459,164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,352,652	73.00
76.00	03020	CARDIAC	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	70,501	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-2,988	408,520	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	-5,244	729,673	90.01
90.02	09002	DIABETES CLINIC	-711	56,987	90.02
90.03	09003	ASTHMA CLINIC	0	0	90.03
90.04	09004	ANDIS CLINIC	-4,166	153,716	90.04
90.05	09005	PRIME TIME	0	119,621	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	351,927	90.06
90.07	04951	ONCOLOGY	-817,540	1,172,668	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	347,852	90.08
91.00	09100	EMERGENCY	-60,478	3,063,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	-709	2,199,403	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,803,552	98,067,166	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	323,806	190.01
190.02	19002	PHYSICIAN BUILDING	0	8,987	190.02
190.03	19003	PRIVATE DUTY	0	1,104,275	190.03
190.04	19004	MARKETING	0	1,012,920	190.04
190.05	19005	SPORTS PHYSICALS	0	61,591	190.05
190.06	19006	FOUNDATION	0	1,345,915	190.06
190.07	19007	ASC	0	7,197	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	57,783	190.08
190.09	19009	HANCOCK OB	0	6,610,942	190.09
190.10	19010	HANCOCK WELLNESS	0	1,103,153	190.10
190.11	19011	MORRISTOWN CLINIC	0	1,800	190.11
190.12	19012	O3PUREMED	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	854,815	190.13
190.14	19014	3 WEST UNIT	0	394,315	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	1,011,164	190.15
190.16	19016	THORACI	0	193,165	190.16
190.17	19017	HANCOCK ENDO	0	108,241	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	455,475	190.18
190.19	19019	HANCOCK RHEUM	0	84,982	190.19

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A Date/Time Prepared: 5/29/2019 9:57 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
200.00	TOTAL (SUM OF LINES 118 through 199)	-15,803,552	112,807,692	200.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 9:57 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	989,487	813,266		1.00
	TOTALS		989,487	813,266		
	B - PLANT					
1.00	OPERATION OF PLANT	7.00	0	1,603		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,210		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	5,125		3.00
4.00	RESPIRATORY THERAPY	65.00	0	3,404		4.00
	TOTALS		0	15,342		
	C - MARKETING					
1.00	MARKETING	190.04	164,977	847,943		1.00
	TOTALS		164,977	847,943		
	D - OUTPATIENT PROCEDURE					
1.00	LABORATORY	60.00	4,823	1,372		1.00
2.00	ELECTROCARDIOLOGY	69.00	22,928	6,525		2.00
	TOTALS		27,751	7,897		
	E - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	12,352,652		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
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
	TOTALS		0	12,352,652		
500.00	Grand Total: Increases		1,182,215	14,037,100		500.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 9:57 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	989,487	813,266	0	1.00
	TOTALS		989,487	813,266		
	B - PLANT					
1.00	PROFESSIONAL BUILDING	190.01	0	15,342	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	15,342		
	C - MARKETING					
1.00	ADMINISTRATIVE & GENERAL	5.00	164,977	847,943	0	1.00
	TOTALS		164,977	847,943		
	D - OUTPATIENT PROCEDURE					
1.00	PHARMACY	15.00	27,751	7,897	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		27,751	7,897		
	E - DRUG RECLASS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	81	0	1.00
2.00	PHARMACY	15.00	0	11,699,726	0	2.00
3.00	PARAMED ED PRGM	23.00	0	2,184	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	12,509	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	22,899	0	5.00
6.00	SUBPROVIDER - IPF	40.00	0	474	0	6.00
7.00	OPERATING ROOM	50.00	0	50,561	0	7.00
8.00	RECOVERY ROOM	51.00	0	1,209	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	299,042	0	9.00
10.00	LABORATORY	60.00	0	457	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	231	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	555	0	12.00
14.00	ELECTROCARDIOLOGY	69.00	0	20,500	0	14.00
15.00	CARDIOPULMONARY	76.01	0	15	0	15.00
16.00	RURAL HEALTH CLINIC	88.00	0	28,988	0	16.00
17.00	WOUND CLINIC	90.01	0	9,861	0	17.00
18.00	ANDIS CLINIC	90.04	0	5	0	18.00
19.00	SHELBYVILLE WOUND CLINIC	90.06	0	5,136	0	19.00
20.00	ONCOLOGY	90.07	0	21,473	0	20.00
21.00	ANDERSON WOMENS CENTER	90.08	0	115	0	21.00
22.00	EMERGENCY	91.00	0	33,941	0	22.00
23.00	HOSPICE	116.00	0	140,889	0	23.00
24.00	ASC	190.07	0	528	0	24.00
25.00	HANCOCK OB	190.09	0	13	0	25.00
26.00	3 WEST UNIT	190.14	0	90	0	26.00
27.00	HANCOCK FOOT & ANKLE	190.18	0	1,170	0	27.00
	TOTALS		0	12,352,652		
500.00	Grand Total: Decreases		1,182,215	14,037,100		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2019 9:57 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,022,119	316	0	316	0	1.00
2.00	Land Improvements	7,498,607	0	0	0	0	2.00
3.00	Buildings and Fixtures	115,068,992	2,739,233	0	2,739,233	22,405	3.00
4.00	Building Improvements	235,570	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	78,715,821	4,411,572	0	4,411,572	3,466,741	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	202,541,109	7,151,121	0	7,151,121	3,489,146	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	202,541,109	7,151,121	0	7,151,121	3,489,146	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,022,435	0	1.00
2.00	Land Improvements	7,498,607	0	2.00
3.00	Buildings and Fixtures	117,785,820	0	3.00
4.00	Building Improvements	235,570	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	79,660,652	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	206,203,084	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	206,203,084	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 9:57 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	9,032,221	0	0	870,967	389,136	1.00
3.00	Total (sum of lines 1-2)	9,032,221	0	0	870,967	389,136	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	10,292,324	1.00
3.00	Total (sum of lines 1-2)	0	10,292,324	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0037

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

Worksheet A-7 Part III

Date/Time Prepared: 5/29/2019 9:57 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	117,785,819	0	117,785,819	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	117,785,819	0	117,785,819	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	9,032,221	-505,381	1.00
3.00	Total (sum of lines 1-2)	0	0	0	9,032,221	-505,381	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-1,537	870,967	389,136	0	9,785,406	1.00
3.00	Total (sum of lines 1-2)	-1,537	870,967	389,136	0	9,785,406	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 9:57 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,328,008			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 9:57 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	HRH MMO RENTAL INCOME	B	-244,762	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.00
33.01	HRH HUMAN RESOURCES MISCELLANEOUS RE	B	-311,329	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	HRH OTHER REVENUE SALES TAX	B	-7,833	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	HRH OTHER REVENUE MISCELLANEOUS REVE	B	-2,237	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HRH ACCT ACCRUALS MISCELLANEOUS REVE	B	-334,989	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HRH MED STAFF SERV QA APPLICATION FE	B	-11,700	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HRH MED STAFF SERV MISCELLANEOUS REV	B	-7,952	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HRH MEDICAL DUES MEDICAL STAFF DUES	B	-35,900	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	HRH PAT FIN. SERV. BUSINESS SERV-COP	B	-2,564	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HRH INFO SERVICES MISCELLANEOUS REVE	B	-162,025	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	HRH HPN IT DEPT MISCELLANEOUS REVENU	B	-361,984	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	HRH ACCOUNTING MISCELLANEOUS REVENUE	B	-182,433	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HRH ACCOUNTING MANAGEMENT FEES	B	-9,945	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HRH EXEC ADMIN MISCELLANEOUS REVENUE	B	-143,369	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	HRH PURCHASING MISCELLANEOUS REVENUE	B	-700	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	HRH COMMUNICATIONS MISCELLANEOUS REV	B	-572	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	HRH COMMUNICATIONS PHONE LEASE REVEN	B	-163,304	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	HRH COMM EDUCATION EDUCATION SERVICE	B	-5,752	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	HRH COMM EDUCATION CAR SEAT STATE FU	B	-1,001	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HRH TOBACCO AWARENE EDUCATION SERVIC	B	-2,604	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	HRH POP HEALTH MISCELLANEOUS REVENUE	B	-200	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.22	HRH GAIN/LOSS GROSS VARIANCE INVENTO	B	21,340	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	HRH PLANT OFFSITE SERVICES	B	-16,494	OPERATION OF PLANT	7.00	0	33.23
33.24	HRH HOUSEKEEPING ENVIRONMENTAL SERVI	B	-159,292	HOUSEKEEPING	9.00	0	33.24
33.25	HRH NUTRITIONAL SER LTACH REVENUE	B	-87,047	DIETARY	10.00	0	33.25
33.26	HRH NUTRITIONAL SER REBATES/REFUNDS	B	-5,993	DIETARY	10.00	0	33.26
33.27	HRH CLINICAL EDUCAT AHA COURSE REVEN	B	-19,337	NURSING ADMINISTRATION	13.00	0	33.27
33.28	HRH CLINICAL EDUCAT EDUCATION SERVIC	B	-623	NURSING ADMINISTRATION	13.00	0	33.28
33.29	HRH OTHER REVENUE REBATES/REFUNDS	B	-24,237	CENTRAL SERVICES & SUPPLY	14.00	0	33.29
33.30	HRH OTHER REVENUE DISCOUNTS EARNED O	B	-8,353	CENTRAL SERVICES & SUPPLY	14.00	0	33.30
33.31	HRH PHARMACY MISCELLANEOUS REVENUE	B	-63,647	PHARMACY	15.00	0	33.31
33.32	HRH PHARMACY REBATES/REFUNDS	B	-32,163	PHARMACY	15.00	0	33.32
33.33	HRH ASSOCIATE PHARM RETAIL PHARMACY-	B	-699,366	PHARMACY	15.00	0	33.33
33.34	HRH ASSOCIATE PHARM HOSPICE PHARMACY	B	-138,464	PHARMACY	15.00	0	33.34
33.35	HRH ASSOCIATE PHARM PHARMACY MEDS TO	B	-15,385	PHARMACY	15.00	0	33.35
33.36	HRH ASSOCIATE PHARM MISCELLANEOUS RE	B	-30,502	PHARMACY	15.00	0	33.36
33.37	HRH HEALTH INFO SER MEDICAL RECORDS-	B	-642	MEDICAL RECORDS & LIBRARY	16.00	0	33.37

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 9:57 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.38	HRH HEALTH INFO SER MISCELLANEOUS RE	B	-56,458	MEDICAL RECORDS & LIBRARY	16.00	0	33.38
33.39	HRH X-RAY SCHOOL TUITION-X-RAY SCHOO	B	-45,560	PARAMED ED PRGM	23.00	0	33.39
33.40	HRH ANDIS UNIT REBATES/REFUNDS	B	-722	ADULTS & PEDIATRICS	30.00	0	33.40
33.41	HRH SURGERY REBATES/REFUNDS	B	-329	OPERATING ROOM	50.00	0	33.41
33.42	HRH OTHER REVENUE SALE OF USED EQUIP	B	-409	RADIOLOGY-DIAGNOSTIC	54.00	0	33.42
33.43	HRH MMO EXPENSE REIMBURSEMENT	B	-24,177	RADIOLOGY-DIAGNOSTIC	54.00	0	33.43
33.44	HRH LAB WATER TESTING	B	-75,160	LABORATORY	60.00	0	33.44
33.45	HRH LAB DIRECT TESTS	B	-53,475	LABORATORY	60.00	0	33.45
33.46	HRH SLEEP STUDY CLINIC MANAGMENT	B	-65,784	RESPIRATORY THERAPY	65.00	0	33.46
33.47	HRH SLEEP STUDY SLEEP STUDY FEES	B	-12,695	RESPIRATORY THERAPY	65.00	0	33.47
33.48	HRH CATH LAB REBATES/REFUNDS	B	-6,100	ELECTROCARDIOLOGY	69.00	0	33.48
33.49	HRH MED ONCOLOGY MISCELLANEOUS REVEN	B	-44,317	ONCOLOGY	90.07	0	33.49
33.50	HRH E R REBATES/REFUNDS	B	-478	EMERGENCY	91.00	0	33.50
33.51	MOW	B	-354,037	DIETARY	10.00	0	33.51
33.52	CAFETERIA GUEST MEALS	B	-138,207	CAFETERIA	11.00	0	33.52
33.53	PHYSICIAN RECRUITMENT FEES	B	-45,154	ADMINISTRATIVE & GENERAL	5.00	0	33.53
33.54	DONATIONS & SPONSORSHIPS	B	-402,781	ADMINISTRATIVE & GENERAL	5.00	0	33.54
33.55	ADVERTISING FEE	B	-97,373	ADMINISTRATIVE & GENERAL	5.00	0	33.55
33.56	ADVERTISING FEE	B	-391,596	ADMINISTRATIVE & GENERAL	5.00	0	33.56
33.57	ADVERTISING FEE	B	-7,713	ADULTS & PEDIATRICS	30.00	0	33.57
33.58	ADVERTISING FEE	B	-1,511	RADIOLOGY-DIAGNOSTIC	54.00	0	33.58
33.59	ADVERTISING FEE	B	0	ONCOLOGY	90.07	0	33.59
33.60	ADVERTISING FEE	B	-709	HOSPICE	116.00	0	33.60
33.61	IHA LOBBYING EXPENSE	B	-2,535	ADMINISTRATIVE & GENERAL	5.00	0	33.61
33.62	AHA LOBBYING EXPENSE	B	-5,640	ADMINISTRATIVE & GENERAL	5.00	0	33.62
33.63	PHY OFFICE BLDG	B	-175,563	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.63
33.64	PHY OFFICE BLDG	B	-11,636	RADIOLOGY-DIAGNOSTIC	54.00	0	33.64
33.65	PHY OFFICE BLDG	A	-2,988	RURAL HEALTH CLINIC	88.00	0	33.65
33.66	INTEREST REVENUE	A	-1,537	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.66
33.67	RENTAL PROPERTIES EXPENSE	A	-85,056	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.67
33.68	RENTAL PROPERTIES EXPENSE	A	-211,725	ADMINISTRATIVE & GENERAL	5.00	0	33.68
33.69	RENTAL PROPERTIES EXPENSE	A	-2,313	OPERATION OF PLANT	7.00	0	33.69
33.70	RENTAL PROPERTIES EXPENSE	A	-81	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.70
33.71	TELEPHONE SERVICES	A	-42,958	ADMINISTRATIVE & GENERAL	5.00	0	33.71
33.72	HAF EXPENSE	A	-4,720,176	ADMINISTRATIVE & GENERAL	5.00	0	33.72
33.73	SELF INSURANCE CLAIM EXPENSE	A	-2,115,231	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.73
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,803,552				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 9:57 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	231,316	231,316	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	67,500	67,500	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	27,044	27,044	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	347,000	347,000	0	0	0	4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	15,000	15,000	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	132,258	132,258	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	42,957	42,957	0	0	0	7.00
8.00	40.00	SUBPROVIDER - IPF	96,000	96,000	0	0	0	8.00
9.00	50.00	OPERATING ROOM	1,278,257	1,278,257	0	0	0	9.00
10.00	50.00	OPERATING ROOM	2,181	2,181	0	0	0	10.00
11.00	60.00	LABORATORY	125,000	96,203	28,797	260,300	452	11.00
12.00	65.00	RESPIRATORY THERAPY	12,000	12,000	0	0	0	12.00
13.00	90.01	WOUND CLINIC	5,244	5,244	0	0	0	13.00
14.00	90.02	DIABETES CLINIC	711	711	0	0	0	14.00
15.00	90.04	ANDIS CLINIC	4,166	4,166	0	0	0	15.00
16.00	90.07	ONCOLOGY	773,223	773,223	0	0	0	16.00
17.00	91.00	EMERGENCY	60,000	60,000	0	0	0	17.00
18.00	53.00	ANESTHESIOLOGY	136,948	136,948	0	0	0	18.00
200.00			3,356,805	3,328,008	28,797		452	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	8.00
9.00	50.00	OPERATING ROOM	0	0	0	0	0	9.00
10.00	50.00	OPERATING ROOM	0	0	0	0	0	10.00
11.00	60.00	LABORATORY	56,565	2,828	0	0	0	11.00
12.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	12.00
13.00	90.01	WOUND CLINIC	0	0	0	0	0	13.00
14.00	90.02	DIABETES CLINIC	0	0	0	0	0	14.00
15.00	90.04	ANDIS CLINIC	0	0	0	0	0	15.00
16.00	90.07	ONCOLOGY	0	0	0	0	0	16.00
17.00	91.00	EMERGENCY	0	0	0	0	0	17.00
18.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	18.00
200.00			56,565	2,828	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	231,316	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	67,500	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	27,044	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	347,000	4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	15,000	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	132,258	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	42,957	7.00
8.00	40.00	SUBPROVIDER - IPF	0	0	0	96,000	8.00
9.00	50.00	OPERATING ROOM	0	0	0	1,278,257	9.00
10.00	50.00	OPERATING ROOM	0	0	0	2,181	10.00
11.00	60.00	LABORATORY	0	56,565	0	96,203	11.00
12.00	65.00	RESPIRATORY THERAPY	0	0	0	12,000	12.00
13.00	90.01	WOUND CLINIC	0	0	0	5,244	13.00
14.00	90.02	DIABETES CLINIC	0	0	0	711	14.00
15.00	90.04	ANDIS CLINIC	0	0	0	4,166	15.00
16.00	90.07	ONCOLOGY	0	0	0	773,223	16.00
17.00	91.00	EMERGENCY	0	0	0	60,000	17.00
18.00	53.00	ANESTHESIOLOGY	0	0	0	136,948	18.00
200.00			0	56,565	0	3,328,008	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	9,785,406	9,785,406				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,967,019	69,773	5,036,792			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,747,363	735,881	945,094	17,428,338	17,428,338	5.00
7.00	00700	OPERATION OF PLANT	6,277,392	494,558	113,154	6,885,104	1,258,094	7.00
9.00	00900	HOUSEKEEPING	2,112,528	61,451	152,400	2,326,379	425,092	9.00
10.00	01000	DIETARY	354,003	322,506	47,122	723,631	132,227	10.00
11.00	01100	CAFETERIA	1,664,546	0	106,043	1,770,589	323,534	11.00
13.00	01300	NURSING ADMINISTRATION	1,513,985	0	130,558	1,644,543	300,502	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	73,877	0	6,109	79,986	14,616	14.00
15.00	01500	PHARMACY	1,645,157	166,485	195,544	2,007,186	366,767	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	764,955	110,601	64,978	940,534	171,861	16.00
23.00	02300	PARAMED ED PRGM	92,788	37,405	13,027	143,220	26,170	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,432,983	633,407	301,338	4,367,728	798,102	30.00
31.00	03100	INTENSIVE CARE UNIT	3,857,752	663,771	340,702	4,862,225	888,460	31.00
40.00	04000	SUBPROVIDER - IPF	1,364,484	177,451	130,932	1,672,867	305,678	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,940,522	699,924	340,795	5,981,241	1,092,934	50.00
51.00	05100	RECOVERY ROOM	358,563	59,002	34,398	451,963	82,586	51.00
53.00	05300	ANESTHESIOLOGY	522	0	0	522	95	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,788,796	723,441	336,873	5,849,110	1,068,790	54.00
60.00	06000	LABORATORY	4,022,251	162,645	170,796	4,355,692	795,903	60.00
65.00	06500	RESPIRATORY THERAPY	1,517,352	65,514	148,524	1,731,390	316,372	65.00
66.00	06600	PHYSICAL THERAPY	1,240,038	108,235	120,898	1,469,171	268,457	66.00
67.00	06700	OCCUPATIONAL THERAPY	352,059	0	35,017	387,076	70,729	67.00
68.00	06800	SPEECH PATHOLOGY	186,013	0	18,104	204,117	37,298	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	940,953	208,538	70,004	1,219,495	222,835	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,579,640	130,583	0	3,710,223	677,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,459,164	0	0	1,459,164	266,629	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,352,652	0	0	12,352,652	2,257,119	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	70,501	63,427	6,836	140,764	25,721	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	408,520	0	24,558	433,078	79,135	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	729,673	80,738	53,461	863,872	157,853	90.01
90.02	09002	DIABETES CLINIC	56,987	0	5,316	62,303	11,384	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	153,716	72,472	13,042	239,230	43,714	90.04
90.05	09005	PRIME TIME	119,621	0	0	119,621	21,858	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	351,927	0	23,990	375,917	68,690	90.06
90.07	04951	ONCOLOGY	1,172,668	386,657	98,140	1,657,465	302,864	90.07
90.08	04950	ANDERSON WOMENS CENTER	347,852	0	34,372	382,224	69,843	90.08
91.00	09100	EMERGENCY	3,063,535	615,206	272,059	3,950,800	721,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	2,199,403	301,411	140,335	2,641,149	482,609	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,067,166	7,151,082	4,494,519	94,890,569	14,154,397	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	323,806	2,037,486	7	2,361,299	431,473	190.01
190.02	19002	PHYSICIAN BUILDING	8,987	0	0	8,987	1,642	190.02
190.03	19003	PRIVATE DUTY	1,104,275	0	58,971	1,163,246	212,556	190.03
190.04	19004	MARKETING	1,012,920	0	17,681	1,030,601	188,319	190.04
190.05	19005	SPORTS PHYSICALS	61,591	0	6,075	67,666	12,364	190.05
190.06	19006	FOUNDATION	1,345,915	67,073	19,876	1,432,864	261,823	190.06
190.07	19007	ASC	7,197	0	0	7,197	1,315	190.07
190.08	19008	OTHER NONREIMBURSABLE	57,783	0	0	57,783	10,559	190.08
190.09	19009	HANCOCK OB	6,610,942	180,318	172,779	6,964,039	1,272,518	190.09
190.10	19010	HANCOCK WELLNESS	1,103,153	0	84,627	1,187,780	217,039	190.10
190.11	19011	MORRISTOWN CLINIC	1,800	0	0	1,800	329	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	854,815	0	64,690	919,505	168,018	190.13
190.14	19014	3 WEST UNIT	394,315	349,447	20,269	764,031	139,609	190.14

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0037

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

Worksheet B Part I

Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
190.15	19015	NEUROLOGY PHYSICIAN	1,011,164	0	63,665	1,074,829	196,400	190.15
190.16	19016	THORACI	193,165	0	0	193,165	35,296	190.16
190.17	19017	HANCOCK ENDO	108,241	0	0	108,241	19,779	190.17
190.18	19018	HANCOCK FOOT & ANKLE	455,475	0	33,633	489,108	89,373	190.18
190.19	19019	HANCOCK RHEUM	84,982	0	0	84,982	15,529	190.19
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)	112,807,692	9,785,406	5,036,792	112,807,692	17,428,338	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	8,143,198					7.00
9.00	00900	HOUSEKEEPING	106,121	2,857,592				9.00
10.00	01000	DIETARY	556,943	47,472	1,460,273			10.00
11.00	01100	CAFETERIA	0	78,227	0	2,172,350		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	70,042	2,015,087	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	118,661	0	6,234	7,116	14.00
15.00	01500	PHARMACY	287,507	86,556	0	103,140	117,743	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	190,999	104,114	0	61,145	69,802	16.00
23.00	02300	PARAMED ED PRGM	64,595	119,931	0	9,714	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,093,844	795,694	441,634	187,458	213,999	30.00
31.00	03100	INTENSIVE CARE UNIT	1,146,278	164,043	594,829	247,931	283,033	31.00
40.00	04000	SUBPROVIDER - IPF	306,444	131,286	304,894	93,003	106,170	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	318,510	0	147,971	168,921	50.00
51.00	05100	RECOVERY ROOM	101,892	117,283	0	19,148	21,858	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	116,593	0	232,381	265,283	54.00
60.00	06000	LABORATORY	0	111,261	0	152,522	174,117	60.00
65.00	06500	RESPIRATORY THERAPY	0	85,214	0	103,029	117,616	65.00
66.00	06600	PHYSICAL THERAPY	186,913	99,036	0	74,740	85,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	23,805	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,339	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	360,129	193,101	0	40,886	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	225,507	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	109,533	0	0	6,667	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	38,994	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	4,216	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	125,154	0	0	8,767	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	14,544	0	90.06
90.07	04951	ONCOLOGY	667,726	0	0	73,184	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	170,610	0	27,298	0	90.08
91.00	09100	EMERGENCY	1,062,411	0	0	186,080	212,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	520,512	0	118,916	93,722	106,992	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,112,508	2,857,592	1,460,273	2,036,960	1,950,398	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	56,666	64,689	190.03
190.04	19004	MARKETING	0	0	0	12,104	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	115,829	0	0	15,509	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	311,394	0	0	31,403	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	603,467	0	0	11,361	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	8,347	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 9:57 am

	Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	9.00	10.00	11.00	13.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	8,143,198	2,857,592	1,460,273	2,172,350	2,015,087	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	226,613					14.00
15.00	01500	PHARMACY	4,828	2,973,727				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,538,455			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	363,630		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,851	0	413,851	0	8,316,161	30.00
31.00	03100	INTENSIVE CARE UNIT	7,543	0	51,675	0	8,246,017	31.00
40.00	04000	SUBPROVIDER - IPF	543	0	42,609	0	2,963,494	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,290	0	543,944	0	8,261,811	50.00
51.00	05100	RECOVERY ROOM	233	0	0	0	794,963	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	617	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,253	0	62,100	363,630	7,960,140	54.00
60.00	06000	LABORATORY	53,792	0	137,799	0	5,781,086	60.00
65.00	06500	RESPIRATORY THERAPY	672	0	0	0	2,354,293	65.00
66.00	06600	PHYSICAL THERAPY	62	0	0	0	2,183,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	21	0	0	0	481,631	67.00
68.00	06800	SPEECH PATHOLOGY	88	0	0	0	251,842	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	853	0	0	0	2,037,299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,495	0	70,713	0	4,815,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,725,793	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,973,727	3,173	0	17,586,671	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	38	0	0	0	282,723	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	512,213	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	487	0	0	0	1,061,206	90.01
90.02	09002	DIABETES CLINIC	21	0	0	0	77,924	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	14	0	0	0	416,879	90.04
90.05	09005	PRIME TIME	0	0	0	0	141,479	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	247	0	0	0	459,398	90.06
90.07	04951	ONCOLOGY	1,358	0	0	0	2,702,597	90.07
90.08	04950	ANDERSON WOMENS CENTER	225	0	0	0	650,200	90.08
91.00	09100	EMERGENCY	7,224	0	212,591	0	6,353,450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,850	0	0	0	3,965,750	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	225,988	2,973,727	1,538,455	363,630	90,385,234	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	2,792,772	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	10,629	190.02
190.03	19003	PRIVATE DUTY	78	0	0	0	1,497,235	190.03
190.04	19004	MARKETING	0	0	0	0	1,231,024	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	80,030	190.05
190.06	19006	FOUNDATION	0	0	0	0	1,826,025	190.06
190.07	19007	ASC	1	0	0	0	8,513	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	68,342	190.08
190.09	19009	HANCOCK OB	362	0	0	0	8,579,716	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	1,404,819	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	2,129	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	1,087,523	190.13
190.14	19014	3 WEST UNIT	43	0	0	0	1,518,511	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	1,279,576	190.15
190.16	19016	THORACI	0	0	0	0	228,461	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	128,020	190.17
190.18	19018	HANCOCK FOOT & ANKLE	141	0	0	0	578,622	190.18

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
190.19	19019	HANCOCK RHEUM	0	0	0	0	100,511	190.19
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	226,613	2,973,727	1,538,455	363,630	112,807,692	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
23.00	02300	PARAMED ED PRGM			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	8,316,161	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,246,017	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,963,494	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	8,261,811	50.00
51.00	05100	RECOVERY ROOM	0	794,963	51.00
53.00	05300	ANESTHESIOLOGY	0	617	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,960,140	54.00
60.00	06000	LABORATORY	0	5,781,086	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,354,293	65.00
66.00	06600	PHYSICAL THERAPY	0	2,183,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	481,631	67.00
68.00	06800	SPEECH PATHOLOGY	0	251,842	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	2,037,299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,815,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,725,793	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,586,671	73.00
76.00	03020	CARDIAC	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	282,723	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	512,213	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	0	1,061,206	90.01
90.02	09002	DIABETES CLINIC	0	77,924	90.02
90.03	09003	ASTHMA CLINIC	0	0	90.03
90.04	09004	ANDIS CLINIC	0	416,879	90.04
90.05	09005	PRIME TIME	0	141,479	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	459,398	90.06
90.07	04951	ONCOLOGY	0	2,702,597	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	650,200	90.08
91.00	09100	EMERGENCY	0	6,353,450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0	3,965,750	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	90,385,234	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	2,792,772	190.01
190.02	19002	PHYSICIAN BUILDING	0	10,629	190.02
190.03	19003	PRIVATE DUTY	0	1,497,235	190.03
190.04	19004	MARKETING	0	1,231,024	190.04
190.05	19005	SPORTS PHYSICALS	0	80,030	190.05
190.06	19006	FOUNDATION	0	1,826,025	190.06
190.07	19007	ASC	0	8,513	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	68,342	190.08
190.09	19009	HANCOCK OB	0	8,579,716	190.09
190.10	19010	HANCOCK WELLNESS	0	1,404,819	190.10
190.11	19011	MORRISTOWN CLINIC	0	2,129	190.11
190.12	19012	O3PUREMED	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	1,087,523	190.13
190.14	19014	3 WEST UNIT	0	1,518,511	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	1,279,576	190.15
190.16	19016	THORACI	0	228,461	190.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
190.17	19017	HANCOCK ENDO	0	128,020	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	578,622	190.18
190.19	19019	HANCOCK RHEUM	0	100,511	190.19
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	112,807,692	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	69,773	69,773	69,773		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	735,881	735,881	13,076	748,957	5.00
7.00	00700	OPERATION OF PLANT	0	494,558	494,558	1,568	54,062	7.00
9.00	00900	HOUSEKEEPING	0	61,451	61,451	2,112	18,267	9.00
10.00	01000	DIETARY	0	322,506	322,506	653	5,682	10.00
11.00	01100	CAFETERIA	0	0	0	1,469	13,903	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,809	12,913	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	85	628	14.00
15.00	01500	PHARMACY	0	166,485	166,485	2,710	15,760	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	110,601	110,601	900	7,385	16.00
23.00	02300	PARAMED ED PRGM	0	37,405	37,405	181	1,125	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	633,407	633,407	4,175	34,295	30.00
31.00	03100	INTENSIVE CARE UNIT	0	663,771	663,771	4,721	38,178	31.00
40.00	04000	SUBPROVIDER - IPF	0	177,451	177,451	1,814	13,135	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	699,924	699,924	4,722	46,965	50.00
51.00	05100	RECOVERY ROOM	0	59,002	59,002	477	3,549	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	4	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	723,441	723,441	4,668	45,927	54.00
60.00	06000	LABORATORY	0	162,645	162,645	2,367	34,201	60.00
65.00	06500	RESPIRATORY THERAPY	0	65,514	65,514	2,058	13,595	65.00
66.00	06600	PHYSICAL THERAPY	0	108,235	108,235	1,675	11,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	485	3,039	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	251	1,603	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	208,538	208,538	970	9,575	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	130,583	130,583	0	29,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	11,457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	97,032	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	63,427	63,427	95	1,105	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	340	3,401	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	80,738	80,738	741	6,783	90.01
90.02	09002	DIABETES CLINIC	0	0	0	74	489	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	72,472	72,472	181	1,878	90.04
90.05	09005	PRIME TIME	0	0	0	0	939	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	332	2,952	90.06
90.07	04951	ONCOLOGY	0	386,657	386,657	1,360	13,014	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	476	3,001	90.08
91.00	09100	EMERGENCY	0	615,206	615,206	3,770	31,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	301,411	301,411	1,945	20,738	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,151,082	7,151,082	62,260	608,271	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	2,037,486	2,037,486	0	18,541	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	71	190.02
190.03	19003	PRIVATE DUTY	0	0	0	817	9,134	190.03
190.04	19004	MARKETING	0	0	0	245	8,092	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	84	531	190.05
190.06	19006	FOUNDATION	0	67,073	67,073	275	11,251	190.06
190.07	19007	ASC	0	0	0	0	57	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	454	190.08
190.09	19009	HANCOCK OB	0	180,318	180,318	2,394	54,682	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	1,173	9,326	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	14	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	896	7,220	190.13
190.14	19014	3 WEST UNIT	0	349,447	349,447	281	5,999	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	882	8,440	190.15

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
190.16	19016	THORACI	0	0	0	0	1,517	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	850	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	466	3,840	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	667	190.19
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	9,785,406	9,785,406	69,773	748,957	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	550,188					7.00
9.00	00900	HOUSEKEEPING	7,170	89,000				9.00
10.00	01000	DIETARY	37,629	1,479	367,949			10.00
11.00	01100	CAFETERIA	0	2,436	0	17,808		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	574	15,296	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,696	0	51	54	14.00
15.00	01500	PHARMACY	19,425	2,696	0	845	894	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,905	3,243	0	501	530	16.00
23.00	02300	PARAMED ED PRGM	4,364	3,735	0	80	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	73,905	24,782	111,280	1,537	1,624	30.00
31.00	03100	INTENSIVE CARE UNIT	77,446	5,109	149,880	2,033	2,148	31.00
40.00	04000	SUBPROVIDER - IPF	20,705	4,089	76,825	762	806	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,920	0	1,213	1,282	50.00
51.00	05100	RECOVERY ROOM	6,884	3,653	0	157	166	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,631	0	1,905	2,014	54.00
60.00	06000	LABORATORY	0	3,465	0	1,250	1,322	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,654	0	845	893	65.00
66.00	06600	PHYSICAL THERAPY	12,629	3,084	0	613	648	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	195	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	85	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	24,332	6,014	0	335	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,236	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	7,401	0	0	55	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	320	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	35	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	8,456	0	0	72	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	119	0	90.06
90.07	04951	ONCOLOGY	45,114	0	0	600	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	5,314	0	224	0	90.08
91.00	09100	EMERGENCY	71,781	0	0	1,525	1,612	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	35,168	0	29,964	768	812	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	480,550	89,000	367,949	16,699	14,805	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	465	491	190.03
190.04	19004	MARKETING	0	0	0	99	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	7,826	0	0	127	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	21,039	0	0	257	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	40,773	0	0	93	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	68	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 9:57 am

	Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	9.00	10.00	11.00	13.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	550,188	89,000	367,949	17,808	15,296	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,514					14.00
15.00	01500	PHARMACY	96	208,911				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	136,065			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	46,890		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77	0	36,602		921,684	30.00
31.00	03100	INTENSIVE CARE UNIT	150	0	4,570		948,006	31.00
40.00	04000	SUBPROVIDER - IPF	11	0	3,768		299,366	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	165	0	48,109		812,300	50.00
51.00	05100	RECOVERY ROOM	5	0	0		73,893	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		4	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45	0	5,492		787,123	54.00
60.00	06000	LABORATORY	1,072	0	12,187		218,509	60.00
65.00	06500	RESPIRATORY THERAPY	13	0	0		85,572	65.00
66.00	06600	PHYSICAL THERAPY	1	0	0		138,421	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		3,719	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	0		1,941	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		0	68.01
69.00	06900	ELECTROCARDIOLOGY	17	0	0		249,781	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,619	0	6,254		183,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		11,457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	208,911	281		306,224	73.00
76.00	03020	CARDIAC	0	0	0		0	76.00
76.01	03160	CARDIOPULMONARY	1	0	0		72,084	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		3,741	88.00
90.00	09000	CLINIC	0	0	0		0	90.00
90.01	09001	WOUND CLINIC	10	0	0		88,592	90.01
90.02	09002	DIABETES CLINIC	0	0	0		598	90.02
90.03	09003	ASTHMA CLINIC	0	0	0		0	90.03
90.04	09004	ANDIS CLINIC	0	0	0		83,059	90.04
90.05	09005	PRIME TIME	0	0	0		939	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	5	0	0		3,408	90.06
90.07	04951	ONCOLOGY	27	0	0		446,772	90.07
90.08	04950	ANDERSON WOMENS CENTER	4	0	0		9,019	90.08
91.00	09100	EMERGENCY	144	0	18,802		743,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	37	0	0		390,843	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,501	208,911	136,065	0	6,884,742	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		2,056,027	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		71	190.02
190.03	19003	PRIVATE DUTY	2	0	0		10,909	190.03
190.04	19004	MARKETING	0	0	0		8,436	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		615	190.05
190.06	19006	FOUNDATION	0	0	0		86,552	190.06
190.07	19007	ASC	0	0	0		57	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0		454	190.08
190.09	19009	HANCOCK OB	7	0	0		258,697	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		10,499	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		14	190.11
190.12	19012	O3PUREMED	0	0	0		0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0		8,116	190.13
190.14	19014	3 WEST UNIT	1	0	0		396,594	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		9,390	190.15
190.16	19016	THORACI	0	0	0		1,517	190.16
190.17	19017	HANCOCK ENDO	0	0	0		850	190.17
190.18	19018	HANCOCK FOOT & ANKLE	3	0	0		4,309	190.18

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
190.19	19019	HANCOCK RHEUM	0	0	0		667	190.19
200.00		Cross Foot Adjustments				46,890	46,890	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,514	208,911	136,065	46,890	9,785,406	202.00

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
23.00	02300	PARAMED ED PRGM			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	921,684	30.00
31.00	03100	INTENSIVE CARE UNIT	0	948,006	31.00
40.00	04000	SUBPROVIDER - IPF	0	299,366	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	812,300	50.00
51.00	05100	RECOVERY ROOM	0	73,893	51.00
53.00	05300	ANESTHESIOLOGY	0	4	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	787,123	54.00
60.00	06000	LABORATORY	0	218,509	60.00
65.00	06500	RESPIRATORY THERAPY	0	85,572	65.00
66.00	06600	PHYSICAL THERAPY	0	138,421	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,719	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,941	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	249,781	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	183,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	306,224	73.00
76.00	03020	CARDIAC	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	72,084	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	3,741	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	0	88,592	90.01
90.02	09002	DIABETES CLINIC	0	598	90.02
90.03	09003	ASTHMA CLINIC	0	0	90.03
90.04	09004	ANDIS CLINIC	0	83,059	90.04
90.05	09005	PRIME TIME	0	939	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	3,408	90.06
90.07	04951	ONCOLOGY	0	446,772	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	9,019	90.08
91.00	09100	EMERGENCY	0	743,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0	390,843	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,884,742	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	2,056,027	190.01
190.02	19002	PHYSICIAN BUILDING	0	71	190.02
190.03	19003	PRIVATE DUTY	0	10,909	190.03
190.04	19004	MARKETING	0	8,436	190.04
190.05	19005	SPORTS PHYSICALS	0	615	190.05
190.06	19006	FOUNDATION	0	86,552	190.06
190.07	19007	ASC	0	57	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	454	190.08
190.09	19009	HANCOCK OB	0	258,697	190.09
190.10	19010	HANCOCK WELLNESS	0	10,499	190.10
190.11	19011	MORRISTOWN CLINIC	0	14	190.11
190.12	19012	O3PUREMED	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	8,116	190.13
190.14	19014	3 WEST UNIT	0	396,594	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	9,390	190.15
190.16	19016	THORACI	0	1,517	190.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
190.17	19017	HANCOCK ENDO	0	850	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	4,309	190.18
190.19	19019	HANCOCK RHEUM	0	667	190.19
200.00		Cross Foot Adjustments	0	46,890	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	9,785,406	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	351,600					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,507	46,998,252				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,441	8,818,739	-17,428,338	95,379,354		5.00
7.00	00700	OPERATION OF PLANT	17,770	1,055,841	0	6,885,104	169,431	7.00
9.00	00900	HOUSEKEEPING	2,208	1,422,043	0	2,326,379	2,208	9.00
10.00	01000	DIETARY	11,588	439,693	0	723,631	11,588	10.00
11.00	01100	CAFETERIA	0	989,487	0	1,770,589	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,218,229	0	1,644,543	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	57,007	0	79,986	0	14.00
15.00	01500	PHARMACY	5,982	1,824,617	0	2,007,186	5,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,974	606,304	0	940,534	3,974	16.00
23.00	02300	PARAMED ED PRGM	1,344	121,555	0	143,220	1,344	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,759	2,811,780	0	4,367,728	22,759	30.00
31.00	03100	INTENSIVE CARE UNIT	23,850	3,179,078	0	4,862,225	23,850	31.00
40.00	04000	SUBPROVIDER - IPF	6,376	1,221,718	0	1,672,867	6,376	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,149	3,179,952	0	5,981,241	0	50.00
51.00	05100	RECOVERY ROOM	2,120	320,969	0	451,963	2,120	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	522	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,994	3,143,350	0	5,849,110	0	54.00
60.00	06000	LABORATORY	5,844	1,593,695	0	4,355,692	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,354	1,385,872	0	1,731,390	0	65.00
66.00	06600	PHYSICAL THERAPY	3,889	1,128,098	0	1,469,171	3,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	326,741	0	387,076	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	168,924	0	204,117	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	7,493	653,207	0	1,219,495	7,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,692	0	0	3,710,223	4,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,459,164	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,352,652	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	2,279	63,782	0	140,764	2,279	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	229,149	0	433,078	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	2,901	498,846	0	863,872	0	90.01
90.02	09002	DIABETES CLINIC	0	49,606	0	62,303	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	2,604	121,691	0	239,230	2,604	90.04
90.05	09005	PRIME TIME	0	0	0	119,621	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	223,854	0	375,917	0	90.06
90.07	04951	ONCOLOGY	13,893	915,742	0	1,657,465	13,893	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	320,720	0	382,224	0	90.08
91.00	09100	EMERGENCY	22,105	2,538,578	0	3,950,800	22,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	10,830	1,309,460	0	2,641,149	10,830	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	256,946	41,938,327	-17,428,338	77,462,231	147,986	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	73,209	65	0	2,361,299	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	8,987	0	190.02
190.03	19003	PRIVATE DUTY	0	550,261	0	1,163,246	0	190.03
190.04	19004	MARKETING	0	164,977	0	1,030,601	0	190.04
190.05	19005	SPORTS PHYSICALS	0	56,681	0	67,666	0	190.05
190.06	19006	FOUNDATION	2,410	185,464	0	1,432,864	2,410	190.06
190.07	19007	ASC	0	0	0	7,197	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	57,783	0	190.08
190.09	19009	HANCOCK OB	6,479	1,612,198	0	6,964,039	6,479	190.09
190.10	19010	HANCOCK WELLNESS	0	789,648	0	1,187,780	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	1,800	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	603,616	0	919,505	0	190.13
190.14	19014	3 WEST UNIT	12,556	189,128	0	764,031	12,556	190.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
190.15	19015	NEUROLOGY PHYSICIAN	0	594,060	0	1,074,829	0	190.15
190.16	19016	THORACI	0	0	0	193,165	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	108,241	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	313,827	0	489,108	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	84,982	0	190.19
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	9,785,406	5,036,792		17,428,338	8,143,198	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.831075	0.107170		0.182727	48.062031	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		69,773		748,957	550,188	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001485		0.007852	3.247269	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: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	393,860					9.00
10.00	01000	DIETARY	6,543	11,715				10.00
11.00	01100	CAFETERIA	10,782	0	841,937			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	27,146	684,126		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,355	0	2,416	2,416	6,169,116	14.00
15.00	01500	PHARMACY	11,930	0	39,974	39,974	131,439	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,350	0	23,698	23,698	0	16.00
23.00	02300	PARAMED ED PRGM	16,530	0	3,765	0	13	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,670	3,543	72,653	72,653	104,832	30.00
31.00	03100	INTENSIVE CARE UNIT	22,610	4,772	96,090	96,090	205,340	31.00
40.00	04000	SUBPROVIDER - IPF	18,095	2,446	36,045	36,045	14,792	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,900	0	57,349	57,349	225,694	50.00
51.00	05100	RECOVERY ROOM	16,165	0	7,421	7,421	6,336	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,070	0	90,064	90,064	61,322	54.00
60.00	06000	LABORATORY	15,335	0	59,113	59,113	1,464,412	60.00
65.00	06500	RESPIRATORY THERAPY	11,745	0	39,931	39,931	18,284	65.00
66.00	06600	PHYSICAL THERAPY	13,650	0	28,967	28,967	1,682	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	9,226	0	572	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	4,007	0	2,395	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	26,615	0	15,846	0	23,229	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,579,705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	2,584	0	1,038	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	15,113	0	13,250	90.01
90.02	09002	DIABETES CLINIC	0	0	1,634	0	563	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	3,398	0	375	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	5,637	0	6,737	90.06
90.07	04951	ONCOLOGY	0	0	28,364	0	36,977	90.07
90.08	04950	ANDERSON WOMENS CENTER	23,515	0	10,580	0	6,118	90.08
91.00	09100	EMERGENCY	0	0	72,119	72,119	196,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	954	36,324	36,324	50,370	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	393,860	11,715	789,464	662,164	6,152,132	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	21,962	21,962	2,116	190.03
190.04	19004	MARKETING	0	0	4,691	0	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	6,011	0	0	190.06
190.07	19007	ASC	0	0	0	0	27	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	0	12,171	0	9,852	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	0	0	4,403	0	1,158	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	3,235	0	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
190.17	19017	HANCOCK ENDO	0	0	0	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	3,831	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,857,592	1,460,273	2,172,350	2,015,087	226,613	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.255350	124.649851	2.580181	2.945491	0.036733	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	89,000	367,949	17,808	15,296	4,514	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.225969	31.408365	0.021151	0.022358	0.000732	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: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,394			16.00
23.00	02300	PARAMED ED PRGM	0	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	913	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	114	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	94	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,200	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137	100		54.00
60.00	06000	LABORATORY	0	304	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	156	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	7	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	469	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	3,394	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		190.02
190.03	19003	PRIVATE DUTY	0	0	0		190.03
190.04	19004	MARKETING	0	0	0		190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		190.05
190.06	19006	FOUNDATION	0	0	0		190.06
190.07	19007	ASC	0	0	0		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0		190.08
190.09	19009	HANCOCK OB	0	0	0		190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		190.11
190.12	19012	O3PUREMED	0	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	0	0		190.13
190.14	19014	3 WEST UNIT	0	0	0		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		190.15
190.16	19016	THORACI	0	0	0		190.16

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 9:57 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)	
			15.00	16.00	23.00	
190.17	19017	HANCOCK ENDO	0	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	190.19
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,973,727	1,538,455	363,630	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29,737.270000	453.286682	3,636.300000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	208,911	136,065	46,890	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2,089.110000	40.089864	468.900000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,316,161		8,316,161	0	8,316,161	30.00
31.00	03100	INTENSIVE CARE UNIT	8,246,017		8,246,017	0	8,246,017	31.00
40.00	04000	SUBPROVIDER - IPF	2,963,494		2,963,494	0	2,963,494	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,261,811		8,261,811	0	8,261,811	50.00
51.00	05100	RECOVERY ROOM	794,963		794,963	0	794,963	51.00
53.00	05300	ANESTHESIOLOGY	617		617	0	617	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,960,140		7,960,140	0	7,960,140	54.00
60.00	06000	LABORATORY	5,781,086		5,781,086	0	5,781,086	60.00
65.00	06500	RESPIRATORY THERAPY	2,354,293	0	2,354,293	0	2,354,293	65.00
66.00	06600	PHYSICAL THERAPY	2,183,701	0	2,183,701	0	2,183,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	481,631	0	481,631	0	481,631	67.00
68.00	06800	SPEECH PATHOLOGY	251,842	0	251,842	0	251,842	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	2,037,299		2,037,299	0	2,037,299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,815,896		4,815,896	0	4,815,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,725,793		1,725,793	0	1,725,793	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,586,671		17,586,671	0	17,586,671	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	282,723		282,723	0	282,723	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	512,213		512,213	0	512,213	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,061,206		1,061,206	0	1,061,206	90.01
90.02	09002	DIABETES CLINIC	77,924		77,924	0	77,924	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	416,879		416,879	0	416,879	90.04
90.05	09005	PRIME TIME	141,479		141,479	0	141,479	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	459,398		459,398	0	459,398	90.06
90.07	04951	ONCOLOGY	2,702,597		2,702,597	0	2,702,597	90.07
90.08	04950	ANDERSON WOMENS CENTER	650,200		650,200	0	650,200	90.08
91.00	09100	EMERGENCY	6,353,450		6,353,450	0	6,353,450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,783,310		2,783,310		2,783,310	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,965,750		3,965,750		3,965,750	116.00
200.00		Subtotal (see instructions)	93,168,544	0	93,168,544	0	93,168,544	200.00
201.00		Less Observation Beds	2,783,310		2,783,310		2,783,310	201.00
202.00		Total (see instructions)	90,385,234	0	90,385,234	0	90,385,234	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 9:57 am

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		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,885,512		6,885,512			30.00
31.00	03100	INTENSIVE CARE UNIT	11,339,967		11,339,967			31.00
40.00	04000	SUBPROVIDER - IPF	3,241,674		3,241,674			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,570,040	12,598,264	21,168,304	0.390292	0.000000	50.00
51.00	05100	RECOVERY ROOM	779,114	1,497,782	2,276,896	0.349143	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	972,051	1,824,836	2,796,887	0.000221	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,339,038	63,589,327	65,928,365	0.120739	0.000000	54.00
60.00	06000	LABORATORY	4,960,084	40,009,004	44,969,088	0.128557	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,175,836	6,057,703	9,233,539	0.254972	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	731,853	4,418,264	5,150,117	0.424010	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	537,729	831,548	1,369,277	0.351741	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	133,208	540,771	673,979	0.373664	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	2,850,450	12,496,124	15,346,574	0.132753	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,035,190	5,931,012	8,966,202	0.537117	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,682,370	1,638,390	4,320,760	0.399419	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,614,503	79,344,797	85,959,300	0.204593	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	433,808	433,808	0.651724	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	16,827	4,075,004	4,091,831	0.259347	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	75,219	75,219	1.035962	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	73,838	73,838	5.645860	0.000000	90.04
90.05	09005	PRIME TIME	100	415,402	415,502	0.340501	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,443,692	1,443,692	0.318211	0.000000	90.06
90.07	04951	ONCOLOGY	1,236	6,512,672	6,513,908	0.414896	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	7,000	3,595,956	3,602,956	0.180463	0.000000	90.08
91.00	09100	EMERGENCY	3,188,614	45,097,189	48,285,803	0.131580	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,726,688	4,726,688	0.588850	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,002,355	2,092,995	3,095,350			116.00
200.00		Subtotal (see instructions)	63,064,751	299,320,285	362,385,036			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	63,064,751	299,320,285	362,385,036			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.390292	50.00
51.00	05100	RECOVERY ROOM	0.349143	51.00
53.00	05300	ANESTHESIOLOGY	0.000221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120739	54.00
60.00	06000	LABORATORY	0.128557	60.00
65.00	06500	RESPIRATORY THERAPY	0.254972	65.00
66.00	06600	PHYSICAL THERAPY	0.424010	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351741	67.00
68.00	06800	SPEECH PATHOLOGY	0.373664	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0.132753	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537117	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.399419	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204593	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.651724	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.259347	90.01
90.02	09002	DIABETES CLINIC	1.035962	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	5.645860	90.04
90.05	09005	PRIME TIME	0.340501	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.318211	90.06
90.07	04951	ONCOLOGY	0.414896	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.180463	90.08
91.00	09100	EMERGENCY	0.131580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.588850	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 9:57 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	8,316,161		8,316,161	0	8,316,161	30.00
31.00	03100	INTENSIVE CARE UNIT	8,246,017		8,246,017	0	8,246,017	31.00
40.00	04000	SUBPROVIDER - IPF	2,963,494		2,963,494	0	2,963,494	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,261,811		8,261,811	0	8,261,811	50.00
51.00	05100	RECOVERY ROOM	794,963		794,963	0	794,963	51.00
53.00	05300	ANESTHESIOLOGY	617		617	0	617	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,960,140		7,960,140	0	7,960,140	54.00
60.00	06000	LABORATORY	5,781,086		5,781,086	0	5,781,086	60.00
65.00	06500	RESPIRATORY THERAPY	2,354,293	0	2,354,293	0	2,354,293	65.00
66.00	06600	PHYSICAL THERAPY	2,183,701	0	2,183,701	0	2,183,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	481,631	0	481,631	0	481,631	67.00
68.00	06800	SPEECH PATHOLOGY	251,842	0	251,842	0	251,842	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	2,037,299		2,037,299	0	2,037,299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,815,896		4,815,896	0	4,815,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,725,793		1,725,793	0	1,725,793	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,586,671		17,586,671	0	17,586,671	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	282,723		282,723	0	282,723	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	512,213		512,213	0	512,213	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,061,206		1,061,206	0	1,061,206	90.01
90.02	09002	DIABETES CLINIC	77,924		77,924	0	77,924	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	416,879		416,879	0	416,879	90.04
90.05	09005	PRIME TIME	141,479		141,479	0	141,479	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	459,398		459,398	0	459,398	90.06
90.07	04951	ONCOLOGY	2,702,597		2,702,597	0	2,702,597	90.07
90.08	04950	ANDERSON WOMENS CENTER	650,200		650,200	0	650,200	90.08
91.00	09100	EMERGENCY	6,353,450		6,353,450	0	6,353,450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,783,310		2,783,310		2,783,310	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,965,750		3,965,750		3,965,750	116.00
200.00		Subtotal (see instructions)	93,168,544	0	93,168,544	0	93,168,544	200.00
201.00		Less Observation Beds	2,783,310		2,783,310		2,783,310	201.00
202.00		Total (see instructions)	90,385,234	0	90,385,234	0	90,385,234	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 9:57 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,885,512		6,885,512			30.00
31.00	03100	INTENSIVE CARE UNIT	11,339,967		11,339,967			31.00
40.00	04000	SUBPROVIDER - IPF	3,241,674		3,241,674			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,570,040	12,598,264	21,168,304	0.390292	0.000000	50.00
51.00	05100	RECOVERY ROOM	779,114	1,497,782	2,276,896	0.349143	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	972,051	1,824,836	2,796,887	0.000221	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,339,038	63,589,327	65,928,365	0.120739	0.000000	54.00
60.00	06000	LABORATORY	4,960,084	40,009,004	44,969,088	0.128557	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,175,836	6,057,703	9,233,539	0.254972	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	731,853	4,418,264	5,150,117	0.424010	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	537,729	831,548	1,369,277	0.351741	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	133,208	540,771	673,979	0.373664	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	2,850,450	12,496,124	15,346,574	0.132753	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,035,190	5,931,012	8,966,202	0.537117	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,682,370	1,638,390	4,320,760	0.399419	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,614,503	79,344,797	85,959,300	0.204593	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	433,808	433,808	0.651724	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	16,827	4,075,004	4,091,831	0.259347	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	75,219	75,219	1.035962	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	73,838	73,838	5.645860	0.000000	90.04
90.05	09005	PRIME TIME	100	415,402	415,502	0.340501	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,443,692	1,443,692	0.318211	0.000000	90.06
90.07	04951	ONCOLOGY	1,236	6,512,672	6,513,908	0.414896	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	7,000	3,595,956	3,602,956	0.180463	0.000000	90.08
91.00	09100	EMERGENCY	3,188,614	45,097,189	48,285,803	0.131580	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,726,688	4,726,688	0.588850	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,002,355	2,092,995	3,095,350			116.00
200.00		Subtotal (see instructions)	63,064,751	299,320,285	362,385,036			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	63,064,751	299,320,285	362,385,036			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 9:57 am

		Title XIX	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.000000	90.01
90.02	09002	DIABETES CLINIC	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	0.000000	90.04
90.05	09005	PRIME TIME	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	90.06
90.07	04951	ONCOLOGY	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	90.08
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/29/2019 9:57 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	921,684	0	921,684	5,172	178.21	30.00
31.00	INTENSIVE CARE UNIT	948,006		948,006	4,759	199.20	31.00
40.00	SUBPROVIDER - IPF	299,366	0	299,366	2,466	121.40	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
200.00	Total (lines 30 through 199)	2,169,056		2,169,056	12,397		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,156	206,011	30.00
31.00	INTENSIVE CARE UNIT	1,868	372,106	31.00
40.00	SUBPROVIDER - IPF	2,003	243,164	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
200.00	Total (lines 30 through 199)	5,027	821,281	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	812,300	21,168,304	0.038373	2,490,351	95,562	50.00
51.00	05100	RECOVERY ROOM	73,893	2,276,896	0.032453	254,682	8,265	51.00
53.00	05300	ANESTHESIOLOGY	4	2,796,887	0.000001	346,455	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	787,123	65,928,365	0.011939	2,069,261	24,705	54.00
60.00	06000	LABORATORY	218,509	44,969,088	0.004859	2,783,102	13,523	60.00
65.00	06500	RESPIRATORY THERAPY	85,572	9,233,539	0.009268	1,619,409	15,009	65.00
66.00	06600	PHYSICAL THERAPY	138,421	5,150,117	0.026877	354,789	9,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,719	1,369,277	0.002716	218,308	593	67.00
68.00	06800	SPEECH PATHOLOGY	1,941	673,979	0.002880	69,869	201	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	249,781	15,346,574	0.016276	1,733,713	28,218	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,825	8,966,202	0.020502	711,728	14,592	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,457	4,320,760	0.002652	2,150,065	5,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	306,224	85,959,300	0.003562	2,864,866	10,205	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	72,084	433,808	0.166166	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,741	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	88,592	4,091,831	0.021651	1,378	30	90.01
90.02	09002	DIABETES CLINIC	598	75,219	0.007950	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	83,059	73,838	1.124881	0	0	90.04
90.05	09005	PRIME TIME	939	415,502	0.002260	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	3,408	1,443,692	0.002361	0	0	90.06
90.07	04951	ONCOLOGY	446,772	6,513,908	0.068587	1,104	76	90.07
90.08	04950	ANDERSON WOMENS CENTER	9,019	3,602,956	0.002503	0	0	90.08
91.00	09100	EMERGENCY	743,862	48,285,803	0.015405	2,939,928	45,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	308,474	4,726,688	0.065262	0	0	92.00
200.00		Total (lines 50 through 199)	4,633,317	337,822,533		20,609,008	271,507	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
200.00		Total (lines 30 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	5,172	0.00	1,156	30.00
31.00	03100	INTENSIVE CARE UNIT		0	4,759	0.00	1,868	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,466	0.00	2,003	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
200.00		Total (lines 30 through 199)		0	12,397		5,027	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Hospital | 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	363,630	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	363,630	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 9:57 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	21,168,304	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,276,896	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,796,887	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	363,630	363,630	65,928,365	0.005516	54.00
60.00	06000	LABORATORY	0	0	0	44,969,088	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,233,539	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,150,117	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,369,277	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	673,979	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,346,574	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,966,202	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,320,760	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	85,959,300	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	433,808	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	0	0	4,091,831	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	0	0	75,219	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	0	0	73,838	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	415,502	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	1,443,692	0.000000	90.06
90.07	04951	ONCOLOGY	0	0	0	6,513,908	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	3,602,956	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	48,285,803	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,726,688	0.000000	92.00
200.00		Total (lines 50 through 199)	0	363,630	363,630	337,822,533		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Hospital | 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	2,490,351	0	3,371,487	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	254,682	0	330,620	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	346,455	0	396,405	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.005516	2,069,261	11,414	18,735,436	103,345	54.00
60.00	06000	LABORATORY	0.000000	2,783,102	0	5,353,174	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,619,409	0	1,586,823	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	354,789	0	60,074	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	218,308	0	38,335	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	69,869	0	66,516	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,733,713	0	3,964,626	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	711,728	0	716,941	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	2,150,065	0	606,092	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,864,866	0	29,291,586	0	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.000000	0	0	182,400	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.000000	1,378	0	1,547,715	0	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0.000000	0	0	18,421	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	88,163	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	585,108	0	90.06
90.07	04951	ONCOLOGY	0.000000	1,104	0	2,102,603	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	0	0	313,373	0	90.08
91.00	09100	EMERGENCY	0.000000	2,939,928	0	8,460,634	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	2,481,869	0	92.00
200.00		Total (lines 50 through 199)		20,609,008	11,414	80,298,401	103,345	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 9:57 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	0.390292	3,371,487	0	0	1,315,864	50.00
51.00	05100	RECOVERY ROOM	0.349143	330,620	0	0	115,434	51.00
53.00	05300	ANESTHESIOLOGY	0.000221	396,405	0	0	88	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120739	18,735,436	0	0	2,262,098	54.00
60.00	06000	LABORATORY	0.128557	5,353,174	0	0	688,188	60.00
65.00	06500	RESPIRATORY THERAPY	0.254972	1,586,823	0	0	404,595	65.00
66.00	06600	PHYSICAL THERAPY	0.424010	60,074	0	0	25,472	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351741	38,335	0	0	13,484	67.00
68.00	06800	SPEECH PATHOLOGY	0.373664	66,516	0	0	24,855	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.132753	3,964,626	0	0	526,316	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537117	716,941	0	0	385,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.399419	606,092	0	0	242,085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204593	29,291,586	0	21,981	5,992,853	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.651724	182,400	0	0	118,874	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.259347	1,547,715	0	0	401,395	90.01
90.02	09002	DIABETES CLINIC	1.035962	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	5.645860	18,421	0	0	104,002	90.04
90.05	09005	PRIME TIME	0.340501	88,163	0	0	30,020	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.318211	585,108	0	0	186,188	90.06
90.07	04951	ONCOLOGY	0.414896	2,102,603	0	0	872,362	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.180463	313,373	0	0	56,552	90.08
91.00	09100	EMERGENCY	0.131580	8,460,634	0	92	1,113,250	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.588850	2,481,869	0	0	1,461,449	92.00
200.00		Subtotal (see instructions)		80,298,401	0	22,073	16,340,505	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		80,298,401	0	22,073	16,340,505	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,497	73.00
76.00	03020	CARDIAC	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	90.04
90.05	09005	PRIME TIME	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	90.06
90.07	04951	ONCOLOGY	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	90.08
91.00	09100	EMERGENCY	0	12	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	4,509	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	4,509	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II | Date/Time Prepared: 5/29/2019 9:57 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	812,300	21,168,304	0.038373	15,564	597	50.00
51.00	05100	RECOVERY ROOM	73,893	2,276,896	0.032453	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4	2,796,887	0.000001	123	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	787,123	65,928,365	0.011939	97,437	1,163	54.00
60.00	06000	LABORATORY	218,509	44,969,088	0.004859	376,139	1,828	60.00
65.00	06500	RESPIRATORY THERAPY	85,572	9,233,539	0.009268	93,211	864	65.00
66.00	06600	PHYSICAL THERAPY	138,421	5,150,117	0.026877	19,403	521	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,719	1,369,277	0.002716	83,356	226	67.00
68.00	06800	SPEECH PATHOLOGY	1,941	673,979	0.002880	11,261	32	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	249,781	15,346,574	0.016276	9,515	155	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,825	8,966,202	0.020502	44,351	909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,457	4,320,760	0.002652	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	306,224	85,959,300	0.003562	238,150	848	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	72,084	433,808	0.166166	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,741	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	88,592	4,091,831	0.021651	348	8	90.01
90.02	09002	DIABETES CLINIC	598	75,219	0.007950	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	83,059	73,838	1.124881	0	0	90.04
90.05	09005	PRIME TIME	939	415,502	0.002260	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	3,408	1,443,692	0.002361	0	0	90.06
90.07	04951	ONCOLOGY	446,772	6,513,908	0.068587	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	9,019	3,602,956	0.002503	0	0	90.08
91.00	09100	EMERGENCY	743,862	48,285,803	0.015405	52,491	809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,726,688	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,324,843	337,822,533		1,041,349	7,960	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 9:57 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	363,630	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	363,630	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 9:57 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	21,168,304	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,276,896	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,796,887	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	363,630	363,630	65,928,365	0.005516	54.00
60.00	06000	LABORATORY	0	0	0	44,969,088	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,233,539	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,150,117	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,369,277	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	673,979	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,346,574	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,966,202	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,320,760	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	85,959,300	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	433,808	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	0	0	4,091,831	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	0	0	75,219	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	0	0	73,838	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	415,502	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	1,443,692	0.000000	90.06
90.07	04951	ONCOLOGY	0	0	0	6,513,908	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	3,602,956	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	48,285,803	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,726,688	0.000000	92.00
200.00		Total (lines 50 through 199)	0	363,630	363,630	337,822,533		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	15,564	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	123	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.005516	97,437	537	0	0	54.00
60.00	06000	LABORATORY	0.000000	376,139	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	93,211	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	19,403	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	83,356	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	11,261	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	9,515	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	44,351	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	238,150	0	0	0	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.000000	348	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.000000	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	52,491	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,041,349	537	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:57 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)	5,172	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,172	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,441	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)	1,156	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)	8,316,161	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)	8,316,161	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)	8,316,161	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)	1,607.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,858,756	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)	1,858,756	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:57 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,246,017	4,759	1,732.72	1,868	3,236,721	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)	4,779,820	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,875,297	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)	578,117	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	282,921	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	861,038	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,014,259	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)	1,731	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,607.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,783,310	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:57 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	921,684	8,316,161	0.110830	2,783,310	308,474	90.00
91.00	Nursing School cost	0	8,316,161	0.000000	2,783,310	0	91.00
92.00	Allied health cost	0	8,316,161	0.000000	2,783,310	0	92.00
93.00	All other Medical Education	0	8,316,161	0.000000	2,783,310	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:57 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)	2,466	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,466	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,466	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,003	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,963,494	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,963,494	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,963,494	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)	1,201.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,407,085	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,407,085	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	212,521	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,619,606	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)	243,164	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,497	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	251,661	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,367,945	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1
Component CCN: 15-S037 | Date/Time Prepared: 5/29/2019 9:57 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	299,366	2,963,494	0.101018	0	0	90.00
91.00	Nursing School cost	0	2,963,494	0.000000	0	0	91.00
92.00	Allied health cost	0	2,963,494	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,963,494	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:57 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)	5,172	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,172	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,441	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)	51	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)	8,316,161	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)	8,316,161	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)	8,316,161	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)	1,607.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	82,004	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)	82,004	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:57 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,246,017	4,759	1,732.72	46	79,705	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)	91,680	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	253,389	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)	1,731	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,607.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,783,310	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 9:57 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	921,684	8,316,161	0.110830	2,783,310	308,474	90.00
91.00	Nursing School cost	0	8,316,161	0.000000	2,783,310	0	91.00
92.00	Allied health cost	0	8,316,161	0.000000	2,783,310	0	92.00
93.00	All other Medical Education	0	8,316,161	0.000000	2,783,310	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 9:57 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		992,940		30.00
31.00	03100	INTENSIVE CARE UNIT		4,456,452		31.00
40.00	04000	SUBPROVIDER - IPF		13,779		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.390292	2,490,351	971,964	50.00
51.00	05100	RECOVERY ROOM	0.349143	254,682	88,920	51.00
53.00	05300	ANESTHESIOLOGY	0.000221	346,455	77	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120739	2,069,261	249,841	54.00
60.00	06000	LABORATORY	0.128557	2,783,102	357,787	60.00
65.00	06500	RESPIRATORY THERAPY	0.254972	1,619,409	412,904	65.00
66.00	06600	PHYSICAL THERAPY	0.424010	354,789	150,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351741	218,308	76,788	67.00
68.00	06800	SPEECH PATHOLOGY	0.373664	69,869	26,108	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.132753	1,733,713	230,156	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537117	711,728	382,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.399419	2,150,065	858,777	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204593	2,864,866	586,132	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.651724	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.259347	1,378	357	90.01
90.02	09002	DIABETES CLINIC	1.035962	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	5.645860	0	0	90.04
90.05	09005	PRIME TIME	0.340501	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.318211	0	0	90.06
90.07	04951	ONCOLOGY	0.414896	1,104	458	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.180463	0	0	90.08
91.00	09100	EMERGENCY	0.131580	2,939,928	386,836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.588850	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		20,609,008	4,779,820	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)		20,609,008		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,631,160		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.390292	15,564	6,075	50.00
51.00	05100	RECOVERY ROOM	0.349143	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000221	123	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120739	97,437	11,764	54.00
60.00	06000	LABORATORY	0.128557	376,139	48,355	60.00
65.00	06500	RESPIRATORY THERAPY	0.254972	93,211	23,766	65.00
66.00	06600	PHYSICAL THERAPY	0.424010	19,403	8,227	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351741	83,356	29,320	67.00
68.00	06800	SPEECH PATHOLOGY	0.373664	11,261	4,208	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.132753	9,515	1,263	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537117	44,351	23,822	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.399419	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204593	238,150	48,724	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.651724	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.259347	348	90	90.01
90.02	09002	DIABETES CLINIC	1.035962	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	5.645860	0	0	90.04
90.05	09005	PRIME TIME	0.340501	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.318211	0	0	90.06
90.07	04951	ONCOLOGY	0.414896	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.180463	0	0	90.08
91.00	09100	EMERGENCY	0.131580	52,491	6,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.588850	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,041,349	212,521	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)		1,041,349		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 9:57 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		145,653		30.00
31.00	03100	INTENSIVE CARE UNIT		72,680		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.390292	85,437	33,345	50.00
51.00	05100	RECOVERY ROOM	0.349143	8,295	2,896	51.00
53.00	05300	ANESTHESIOLOGY	0.000221	8,673	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120739	23,597	2,849	54.00
60.00	06000	LABORATORY	0.128557	50,240	6,459	60.00
65.00	06500	RESPIRATORY THERAPY	0.254972	32,496	8,286	65.00
66.00	06600	PHYSICAL THERAPY	0.424010	3,471	1,472	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351741	1,987	699	67.00
68.00	06800	SPEECH PATHOLOGY	0.373664	827	309	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.132753	15,882	2,108	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.537117	21,258	11,418	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.399419	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204593	86,983	17,796	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.651724	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.259347	524	136	90.01
90.02	09002	DIABETES CLINIC	1.035962	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	5.645860	0	0	90.04
90.05	09005	PRIME TIME	0.340501	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.318211	0	0	90.06
90.07	04951	ONCOLOGY	0.414896	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.180463	0	0	90.08
91.00	09100	EMERGENCY	0.131580	29,674	3,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.588850	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		369,344	91,680	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		369,344		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 9:57 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)	5,407,642	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,758,212	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)	5,616	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)	56.26	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)	2.62	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.89	31.00
32.00	Sum of lines 30 and 31	19.51	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.43	33.00
34.00	Disproportionate share adjustment (see instructions)	97,277	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/29/2019 9:57 am

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,163	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000091834	0.000108296	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	621,412	895,918	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	464,782	225,821	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	690,603		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)	7,959,350		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)	7,959,350	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	584,449	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	9,271	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)	11,414	58.00
59.00	Total (sum of amounts on lines 49 through 58)	8,564,484	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	8,564,484	61.00
62.00	Deductibles billed to program beneficiaries	953,864	62.00
63.00	Coinsurance billed to program beneficiaries	4,355	63.00
64.00	Allowable bad debts (see instructions)	0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,606,265	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)	53,190	70.93
70.94	HRR adjustment amount (see instructions)	-10,709	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/29/2019 9:57 am

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2018	66,392	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)	2019	237,840	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,952,978	71.00
71.01	Sequestration adjustment (see instructions)		159,060	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		7,634,982	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)		158,936	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		113,539	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)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2019 9:57 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,407,642	0	5,407,642		5,407,642	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,758,212	0		1,758,212	1,758,212	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	5,616	0	5,616	0	5,616	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	0.0543	0.0543	0.0543	0.0543		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	97,277	0	73,409	23,868	97,277	11.00
11.01	Uncompensated care payments	36.00	690,603	0	464,782	225,821	690,603	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	7,959,350	0	5,951,449	2,007,901	7,959,350	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	7,959,350	0	5,951,449	2,007,901	7,959,350	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	584,449	0	-142,389	726,838	584,449	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 5/29/2019 9:57 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	5,809,060	2,734,739	8,543,799	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	583,560	0	-143,054	726,614	583,560	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	889	0	665	224	889	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	584,449	0	-142,389	726,838	584,449	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				0.011429	0.086970		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			66,392		66,392	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				237,840	237,840	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2019 9:57 am
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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,407,642	5,407,642		5,407,642	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,758,212		1,758,212	1,758,212	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	5,616	5,616	0	5,616	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	0.0543	0.0543	0.0543		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	97,277	73,409	23,868	97,277	11.00
11.01	Uncompensated care payments	36.00	690,603	464,782	225,821	690,603	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	7,959,350	5,951,449	2,007,901	7,959,350	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	7,959,350	5,951,449	2,007,901	7,959,350	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	584,449	-142,389	726,838	584,449	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			5,809,060	2,734,739	8,543,799	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2019 9:57 am
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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	583,560	-143,054	726,614	583,560	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	889	665	224	889	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	584,449	-142,389	726,838	584,449	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	66,392	66,392		66,392	28.00
29.00	Low volume adjustment on or after October 1	70.97	237,840		237,840	237,840	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	53,190	48,306	4,884	53,190	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	-10,709	-6,489	-4,220	-10,709	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part B Date/Time Prepared: 5/29/2019 9:57 am

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,509	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	16,237,160	2.00
3.00	OPPS payments	13,800,356	3.00
4.00	Outlier payment (see instructions)	72,164	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	103,345	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,509	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	22,073	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)	22,073	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)	22,073	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	17,564	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)	4,509	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)	13,975,865	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)	2,593,487	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)	11,386,887	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)	11,386,887	30.00
31.00	Primary payer payments	772	31.00
32.00	Subtotal (line 30 minus line 31)	11,386,115	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)	11,386,115	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)	11,386,115	40.00
40.01	Sequestration adjustment (see instructions)	227,722	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	11,259,820	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-101,427	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 9:57 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		7,569,616		11,053,060	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	65,366	12/31/2018	206,760	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)		65,366		206,760	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)		7,634,982		11,259,820	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		158,936		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		101,427	6.02
7.00	Total Medicare program liability (see instructions)		7,793,918		11,158,393	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 9:57 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		1,924,330		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,924,330		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		526		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,924,856		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 9:57 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: 15-0037 | Component CCN: 15-S037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part II | Date/Time Prepared: 5/29/2019 9:57 am

Title XVIII | Subprovider - IPF | PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,108,250	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)	6.756164	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,108,250	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,108,250	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,108,250	18.00
19.00	Deductibles	144,648	19.00
20.00	Subtotal (line 18 minus line 19)	1,963,602	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	1,963,602	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,963,602	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)	537	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)	1,964,139	31.00
31.01	Sequestration adjustment (see instructions)	39,283	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,924,330	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)	526	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: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part VII Date/Time Prepared: 5/29/2019 9:57 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	253,389		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)	253,389	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)	253,389	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	218,332		8.00
9.00	Ancillary service charges	369,344	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)	587,676	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)	587,676	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	334,287	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)	253,389	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)	253,389	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)	253,389	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)	253,389	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	253,389	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)	253,389	0	40.00
41.00	Interim payments	372,822	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-119,433	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 9:57 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	17,952,975	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	15,626,269	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	31,980,240	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	80,683,499	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)	146,242,983	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	8,521,042	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	118,021,389	0	0	0	15.00
16.00	Accumulated depreciation	-142,546,489	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	83,852,459	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	67,848,401	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	27,549,240	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	27,549,240	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	241,640,624	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,101,607	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,361,013	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	7,101,754	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,564,374	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,564,374	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	222,076,250				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)	222,076,250	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	241,640,624	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 9:57 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		223,250,317		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,174,067				2.00
3.00	Total (sum of line 1 and line 2)		222,076,250		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)		222,076,250		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)		222,076,250		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2019 9:57 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,885,512		6,885,512	1.00
2.00	SUBPROVIDER - IPF	3,241,674		3,241,674	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,127,186		10,127,186	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,339,967		11,339,967	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,339,967		11,339,967	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,467,153		21,467,153	17.00
18.00	Ancillary services	37,381,467	231,211,628	268,593,095	18.00
19.00	Outpatient services	3,213,777	66,015,659	69,229,436	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	1,002,355	2,092,995	3,095,350	26.00
27.00	NRCC	0	923,565	923,565	27.00
27.01	SELF-INSURANCE	526,939	2,481,573	3,008,512	27.01
27.02	DIETARY SERVICES	0	15,726	15,726	27.02
27.03	PRO FEES	860	844,128	844,988	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	63,592,551	303,585,274	367,177,825	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		128,611,244		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)		128,611,244		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/29/2019 9:57 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	367,177,825	1.00
2.00	Less contractual allowances and discounts on patients' accounts	244,906,082	2.00
3.00	Net patient revenues (line 1 minus line 2)	122,271,743	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	128,611,244	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,339,501	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	11,919,053	24.00
24.01	OTHER NON-OPERATING INCOME	-4,377,640	24.01
25.00	Total other income (sum of lines 6-24)	7,541,413	25.00
26.00	Total (line 5 plus line 25)	1,201,912	26.00
27.00	LOSS ON SALE OF EQUIPMENT	2,375,979	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,375,979	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,174,067	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O | Date/Time Prepared: 5/29/2019 9:57 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*	194,685	550,814	745,499	0	745,499	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	149,509	149,509	0	149,509	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	351	351	0	351	7.00
8.00	DIETARY*	0	5,873	5,873	0	5,873	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	50,370	50,370	0	50,370	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	9,820	9,820	0	9,820	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	140,889	140,889	-140,889	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	182	0	182	0	182	26.00
27.00	NURSE PRACTITIONER**	149	0	149	0	149	27.00
28.00	REGISTERED NURSE**	756,049	84,162	840,211	0	840,211	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	25,171	25,171	0	25,171	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)**	179,901	0	179,901	0	179,901	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*	178,494	14,582	193,076	0	193,076	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	1,309,460	1,031,541	2,341,001	-140,889	2,200,112	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O | Date/Time Prepared: 5/29/2019 9:57 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*	-709	744,790	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	149,509	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	351	7.00
8.00	DIETARY*	0	5,873	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	50,370	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	9,820	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	182	26.00
27.00	NURSE PRACTITIONER**	0	149	27.00
28.00	REGISTERED NURSE**	0	840,211	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	25,171	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	179,901	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	193,076	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	-709	2,199,403	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0037 Hospice CCN: 15-1547	Period: From 01/01/2018 To 12/31/2018	Worksheet O-2 Date/Time Prepared: 5/29/2019 9:57 am
		Hospice I	

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	149	0	149	0	149	27.00
28.00	REGISTERED NURSE	339,225	37,762	376,987	0	376,987	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	11,294	11,294	0	11,294	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)	80,718	0	80,718	0	80,718	46.00
100.00	TOTAL *	420,092	49,056	469,148	0	469,148	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	149	27.00
28.00	REGISTERED NURSE	0	376,987	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	11,294	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	80,718	46.00
100.00	TOTAL *	0	469,148	100.00

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

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-3 | Date/Time Prepared: 5/29/2019 9:57 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	137	0	137	0	137	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	313,766	34,928	348,694	0	348,694	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	10,446	10,446	0	10,446	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)	74,660	0	74,660	0	74,660	46.00
100.00	TOTAL *	388,563	45,374	433,937	0	433,937	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	137	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	348,694	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	10,446	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	74,660	46.00
100.00	TOTAL *	0	433,937	100.00

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

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-4 | Date/Time Prepared: 5/29/2019 9:57 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	45	0	45	0	45	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	103,058	11,472	114,530	0	114,530	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	3,431	3,431	0	3,431	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)	24,523	0	24,523	0	24,523	46.00
100.00	TOTAL *	127,626	14,903	142,529	0	142,529	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	45	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	114,530	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	3,431	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	24,523	46.00
100.00	TOTAL *	0	142,529	100.00

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

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-5 | Date/Time Prepared: 5/29/2019 9:57 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	301,411	301,411	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	140,335	140,335	3.00
4.00	ADMINISTRATIVE & GENERAL	744,790	576,331	1,321,121	4.00
5.00	PLANT OPERATION & MAINTENANCE	149,509	520,512	670,021	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	351	0	351	7.00
8.00	DIETARY	5,873	118,916	124,789	8.00
9.00	NURSING ADMINISTRATION	0	106,992	106,992	9.00
10.00	ROUTINE MEDICAL SUPPLIES	50,370	1,850	52,220	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	9,820		9,820	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	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	469,148		469,148	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	433,937		433,937	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	142,529		142,529	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	193,076		193,076	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	2,199,403	1,766,347	3,965,750	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

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

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

Worksheet O-6 Part I

Date/Time Prepared: 5/29/2019 9:57 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	301,411	301,411				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	140,335	0	0	140,335		3.00
4.00	ADMINISTRATIVE & GENERAL	1,321,121	0	0	0	1,321,121	4.00
5.00	PLANT OPERATION & MAINTENANCE	670,021	0	0	0	670,021	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	351	0	0	0	351	7.00
8.00	DIETARY	124,789	0	0	0	124,789	8.00
9.00	NURSING ADMINISTRATION	106,992	0	0	0	106,992	9.00
10.00	ROUTINE MEDICAL SUPPLIES	52,220	0	0	0	52,220	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	9,820	0	0	0	9,820	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		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	469,148			62,966	532,114	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	433,937	0	0	58,240	492,177	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	142,529	301,411	0	19,129	463,069	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	193,076	0	0	0	193,076	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	3,965,750	301,411	0	140,335	3,965,750	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part I | Date/Time Prepared: 5/29/2019 9:57 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	1,321,121					4.00
5.00	PLANT OPERATION & MAINTENANCE	334,707	1,004,728				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	175	0		526		7.00
8.00	DIETARY	62,338	0		0	187,127	8.00
9.00	NURSING ADMINISTRATION	53,448	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	26,086	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	4,906	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	265,817					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	245,867	0	0	263	73,383	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	231,326	1,004,728	0	263	113,744	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	96,451	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	1,321,121	1,004,728	0	526	187,127	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part I | Date/Time Prepared: 5/29/2019 9:57 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	160,440					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	78,306				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			14,726		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	142,856	69,723	0	4,908	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	6,896	3,366	0	4,909	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	10,688	5,217	0	4,909	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	160,440	78,306	0	14,726	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part I | Date/Time Prepared: 5/29/2019 9:57 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		1,015,418	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	826,861	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	1,833,944	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		289,527	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	0	0	0	0	3,965,750	100.00

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part II | Date/Time Prepared: 5/29/2019 9:57 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	317					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,309,460			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-1,321,121	2,644,629	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	670,021	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	351	7.00
8.00	DIETARY	0	0	0	0	124,789	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	106,992	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	52,220	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	9,820	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	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			587,530	0	532,114	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	543,435	0	492,177	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	317	0	178,495	0	463,069	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	193,076	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)	301,411	0	140,335		1,321,121	100.00
101.00	UNIT COST MULTIPLIER	950.823344	0.000000	0.107170		0.499549	101.00

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part II | Date/Time Prepared: 5/29/2019 9:57 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	317					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		100			7.00
8.00	DIETARY	0		0	153		8.00
9.00	NURSING ADMINISTRATION	0		0		1,396	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					1,243	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	50	60	60	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	317	0	50	93	93	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	1,004,728	0	526	187,127	160,440	100.00
101.00	UNIT COST MULTIPLIER	3,169.488959	0.000000	5.260000	1,223.052288	114.928367	101.00

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part II | Date/Time Prepared: 5/29/2019 9:57 am

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,396					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			99			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	99	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	1,243	0	33	0	33	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	60	0	33	0	33	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	93	0	33	0	33	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)	78,306	0	14,726	0	0	100.00
101.00	UNIT COST MULTIPLIER	56.093123	0.000000	148.747475	0.000000	0.000000	101.00

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-6 Part II | Date/Time Prepared: 5/29/2019 9:57 am

Hospice I

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

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

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-7 | Date/Time Prepared: 5/29/2019 9:57 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	0.424010	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.351741	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.373664	0	0	0	3.00
3.01	OCCUPATIONAL HEALTH	68.01	0.000000	0	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.204593	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.128557	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.537117	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CARDIAC	76.00	0.000000	0	0	0	10.00
10.01	CARDIOPULMONARY	76.01	0.651724	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0037 | Hospice CCN: 15-1547 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-8 | Date/Time Prepared: 5/29/2019 9:57 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)			1,015,418	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			1,243	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			816.91	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	1,243	0		9.00
10.00	Program cost (line 8 times line 9)	1,015,419	0		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)			826,861	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			60	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			13,781.02	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	60	0		14.00
15.00	Program cost (line 13 times line 14)	826,861	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			1,833,944	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			93	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			19,719.83	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	93	0		19.00
20.00	Program cost (line 18 times line 19)	1,833,944	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,676,223	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			1,396	22.00
23.00	Average cost per diem (line 21 divided by line 22)			2,633.40	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/29/2019 9:57 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	583,560	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	889	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)	22.78	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)	584,449	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1

Component CCN: 15-3987 | Date/Time Prepared: 5/29/2019 9:57 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	87,845	0	87,845	0	87,845	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	8,693	0	8,693	0	8,693	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	59,965	0	59,965	0	59,965	9.00
10.00	Subtotal (sum of lines 1 through 9)	156,503	0	156,503	0	156,503	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	156,503	0	156,503	0	156,503	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	28,988	28,988	-28,988	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	28,988	28,988	-28,988	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	72,646	182,359	255,005	0	255,005	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	72,646	182,359	255,005	0	255,005	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	229,149	211,347	440,496	-28,988	411,508	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 9:57 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	87,845	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	8,693	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	59,965	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	156,503	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	156,503	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-2,988	252,017	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,988	252,017	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,988	408,520	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0037 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2

Component CCN: 15-3987 | Date/Time Prepared: 5/29/2019 9:57 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.86	3,204	2,100	1,806		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.86	3,204		1,806	3,204	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.86	3,204			3,204	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	156,503	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	156,503	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	252,017	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	103,693	15.00
16.00	Total overhead (sum of lines 14 and 15)	355,710	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	355,710	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	355,710	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	512,213	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 9:57 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		512,213	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		28,801	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		483,412	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,204	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,204	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		150.88	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	243	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	20,278	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	20,278	16.00
16.01	Total program charges (see instructions)(from contractor's records)		30,633	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		973	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		644	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		14,093	16.04
16.05	Total program cost (see instructions)	0	14,737	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,018	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,528	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		14,737	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,810	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		26,547	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		26,547	26.00
26.01	Sequestration adjustment (see instructions)		531	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		14,271	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		11,745	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 9:57 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	156,503	156,503	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000803	0.010238	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	126	1,602	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,127	3,945	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,253	5,547	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	156,503	156,503	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	355,710	355,710	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.020786	0.035443	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	7,394	12,607	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	10,647	18,154	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	20	225	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	532.35	80.68	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	9	87	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	4,791	7,019	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		28,801	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		11,810	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 9:57 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		14,271	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		14,271	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		11,745	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		26,016	7.00

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