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: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/26/2018 2:20 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2018 Time: 2:20 pm
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 FAYETTE REGIONAL HEALTH SYSTEM (15-0064) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	168,146	-14,710	0	-75,797	1.00
2.00	Subprovider - IPF	0	23,758	0		122,973	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	191,904	-14,710	0	47,176	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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 10:28 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1941 VIRGINIA AVE	PO Box:			1.00
2.00	City: CONNERSVILLE	State: IN	Zip Code: 47331	County: FAYETTE	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	FAYETTE REGIONAL HEALTH SYSTEM	150064	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	FAYETTE REGIONAL HEALTH SYSTEM	15S064	99915	4	10/01/2013	N	P	O	4.00
5.00	Subprovider - IRF	FAYETTE REGIONAL HEALTH SYSTEM	15T064	99915	5	10/01/2003	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FAYETTE REGIONAL HEALTH SYSTEM	15U064	99915		06/25/2009	N	P	P	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	FAYETTE MEMORIAL HOME HEALTH	157097	99915		01/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	FMH HOME HEALTHCARE & HOSPICE	151548	99915		02/02/1996				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	94	542	0	0	260	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 10:28 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 10:28 am

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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. 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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 10:28 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 10:28 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 10:28 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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	386,059	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	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 10:28 am

	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	09/30/2017	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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2018 10:28 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.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/13/2017	Y	12/13/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 10:28 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		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.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7957		KCSMITH@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 10:28 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2018 10:28 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	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)		25	9,125	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	20	7,300	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		45	16,425	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		57				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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 10:28 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)	835	68	1,763			1.00
2.00	HMO and other (see instructions)	0	772				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)	835	68	1,763			7.00
8.00	INTENSIVE CARE UNIT	169	0	271			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		24	324			13.00
14.00	Total (see instructions)	1,004	92	2,358	0.00	321.35	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,585	195	2,242	0.00	5.09	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	10.29	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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	143	0	390	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	336.73	27.00
28.00	Observation Bed Days		0	491			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	32	41			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 10:28 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	292	34	688	1.00
2.00	HMO and other (see instructions)			0	214		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	292	34	688	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	119	29	187	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2018 10:28 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	18,986,095	0	18,986,095	768,462.00	24.71	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		291,926	0	291,926	1,632.00	178.88	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		3,152,345	0	3,152,345	25,019.00	126.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,106,699	46,192	3,152,891	146,863.00	21.47	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		597,975	0	597,975	7,415.00	80.64	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		577,119	0	577,119	5,159.00	111.87	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,959,533	0	2,959,533			17.00
18.00	Wage-related costs (other) (see instructions)		154,451	0	154,451			18.00
19.00	Excluded areas		748,062	0	748,062			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		26,264	0	26,264			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		309,692	0	309,692			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	144,174	168,320	312,494	7,585.00	41.20	26.00
27.00	Administrative & General	5.00	2,146,773	-614,302	1,532,471	84,281.00	18.18	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2018 10:28 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.)		1,321,179	0	1,321,179	26,021.00	50.77	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	270,678	10,886	281,564	13,609.00	20.69	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	516,249	23,239	539,488	47,731.00	11.30	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	531,412	-291,719	239,693	17,610.00	13.61	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	314,661	314,661	21,475.00	14.65	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	697,039	14,624	711,663	18,830.00	37.79	38.00
39.00	Central Services and Supply	14.00	71,358	3,662	75,020	5,132.00	14.62	39.00
40.00	Pharmacy	15.00	312,276	5,914	318,190	10,406.00	30.58	40.00
41.00	Medical Records & Medical Records Library	16.00	674,272	74,380	748,652	32,017.00	23.38	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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 2/26/2018 10:28 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)		17,154,929	0	17,154,929	769,464.00	22.29	1.00
2.00	Excluded area salaries (see instructions)		3,106,699	46,192	3,152,891	146,863.00	21.47	2.00
3.00	Subtotal salaries (line 1 minus line 2)		14,048,230	-46,192	14,002,038	622,601.00	22.49	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,175,094	0	1,175,094	12,574.00	93.45	4.00
5.00	Subtotal wage-related costs (see inst.)		3,140,248	0	3,140,248	0.00	22.43	5.00
6.00	Total (sum of lines 3 thru 5)		18,363,572	-46,192	18,317,380	635,175.00	28.84	6.00
7.00	Total overhead cost (see instructions)		6,685,410	-290,335	6,395,075	284,697.00	22.46	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 2/26/2018 10:28 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	-10,861	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,896,267	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	-86,801	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-62,224	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)	-97,874	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	60,339	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	1,335,343	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	9,362	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	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,043,551	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER	154,451	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part V | Date/Time Prepared: 2/26/2018 10:28 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	597,975	4,043,551	1.00
2.00	Hospital	597,975	4,043,551	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0064 | Component CCN: 15-7097 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-4 | Date/Time Prepared: 2/26/2018 10:28 am

Home Health Agency I | PPS

						1.00	
0.00	County				FAYETTE		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	11	0	0	11	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	9.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	1.01	0.00	1.01	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			17140			20.00
20.01				99915			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	22	0	1	28	51	21.00
22.00	Skilled Nursing Visit Charges	2,794	0	127	3,556	6,477	22.00
23.00	Physical Therapy Visits	12	0	0	2	14	23.00
24.00	Physical Therapy Visit Charges	1,656	0	0	276	1,932	24.00
25.00	Occupational Therapy Visits	19	0	0	3	22	25.00
26.00	Occupational Therapy Visit Charges	2,622	0	0	414	3,036	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	32	0	0	24	56	31.00
32.00	Home Health Aide Visit Charges	2,432	0	0	1,824	4,256	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	85	0	1	57	143	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	9,504	0	127	6,070	15,701	35.00
36.00	Total Number of Episodes (standard/non outlier)	4		1	6	11	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	138	0	43	114	295	38.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA | Provider CCN: 15-0064 | Hospice CCN: 15-1548 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-9 PARTS I THROUGH IV | Date/Time Prepared: 2/26/2018 10:28 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	0	0	36	36	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	0	0	36	36	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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/26/2018 10:28 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)	0.346528	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,864,633	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?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	4,187,799	5.00
6.00	Medicaid charges	21,395,760	6.00
7.00	Medicaid cost (line 1 times line 6)	7,414,230	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	4,863	9.00
10.00	Stand-alone CHIP charges	4,863	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	1,685	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)	0	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)	1,017,605	0	1,017,605	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	352,629	0	352,629	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)	352,629	0	352,629	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?		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)	2,004,078	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	169,012	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	260,019	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	1,744,059	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	695,372	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,048,001	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,048,001	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,262,010	2,262,010	0	2,262,010	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144,174	4,264,194	4,408,368	168,320	4,576,688	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,146,773	5,598,356	7,745,129	-593,317	7,151,812	5.00
7.00	00700	OPERATION OF PLANT	270,678	2,265,861	2,536,539	-906,105	1,630,434	7.00
7.01	00701	OPERATION OF PLANT	0	0	0	916,991	916,991	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,496	124,496	0	124,496	8.00
9.00	00900	HOUSEKEEPING	516,249	100,390	616,639	23,239	639,878	9.00
10.00	01000	DIETARY	531,412	354,911	886,323	-501,870	384,453	10.00
11.00	01100	CAFETERIA	0	0	0	524,812	524,812	11.00
13.00	01300	NURSING ADMINISTRATION	697,039	2,835	699,874	14,624	714,498	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,358	1,024,013	1,095,371	-288,267	807,104	14.00
15.00	01500	PHARMACY	312,276	4,778,908	5,091,184	5,914	5,097,098	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	674,272	160,572	834,844	74,380	909,224	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,140,506	240,180	1,380,686	-323,816	1,056,870	30.00
31.00	03100	INTENSIVE CARE UNIT	597,102	92,750	689,852	15,136	704,988	31.00
40.00	04000	SUBPROVIDER - IPF	808,476	729,227	1,537,703	3,120	1,540,823	40.00
41.00	04100	SUBPROVIDER - IRF	0	6,250	6,250	0	6,250	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	345,585	345,585	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	618,231	1,261,248	1,879,479	12,101	1,891,580	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	938,158	1,592,328	2,530,486	36,042	2,566,528	54.00
60.00	06000	LABORATORY	651,890	1,209,235	1,861,125	27,863	1,888,988	60.00
65.00	06500	RESPIRATORY THERAPY	366,554	50,873	417,427	6,575	424,002	65.00
66.00	06600	PHYSICAL THERAPY	473,853	14,911	488,764	9,519	498,283	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	184,162	13,787	197,949	3,487	201,436	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	291,929	291,929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,171,587	809,834	1,981,421	22,517	2,003,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04050	CLINIC	4,373,122	1,591,560	5,964,682	88,949	6,053,631	93.00
93.01	04950	BIC	0	21,016	21,016	185	21,201	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	24,151	14,932	39,083	274	39,357	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	4,847	4,847	164	5,011	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,712,023	28,589,524	45,301,547	-21,649	45,279,898	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTER	89,621	6,941	96,562	3,412	99,974	191.01
191.02	19102	WELLNESS	83,073	101,872	184,945	1,590	186,535	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,927	6,230	17,157	1,883	19,040	192.00
192.01	19201	RFE	0	1,998	1,998	0	1,998	192.01
192.02	19202	MARKETING	65,010	140,848	205,858	-29,393	176,465	192.02
192.03	19203	FOUNDATION	0	0	0	0	0	192.03
192.06	19206	HEART CENTER	0	0	0	0	0	192.06
192.07	19207	WVCP	1,744,765	655,141	2,399,906	38,657	2,438,563	192.07
192.08	19208	OCCUPATIONAL MED	0	3,190	3,190	0	3,190	192.08
192.10	19210	HOSPITALIST	280,676	883,343	1,164,019	5,500	1,169,519	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	1,644	1,644	0	1,644	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	18,986,095	30,390,731	49,376,826	0	49,376,826	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-22,443	2,239,567		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,576,688		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,248,228	5,903,584		5.00
7.00	00700	OPERATION OF PLANT	-382	1,630,052		7.00
7.01	00701	OPERATION OF PLANT	0	916,991		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,496		8.00
9.00	00900	HOUSEKEEPING	0	639,878		9.00
10.00	01000	DIETARY	0	384,453		10.00
11.00	01100	CAFETERIA	-214,365	310,447		11.00
13.00	01300	NURSING ADMINISTRATION	-55	714,443		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	807,104		14.00
15.00	01500	PHARMACY	-2,728,879	2,368,219		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,248	899,976		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,056,870		30.00
31.00	03100	INTENSIVE CARE UNIT	0	704,988		31.00
40.00	04000	SUBPROVIDER - IPF	0	1,540,823		40.00
41.00	04100	SUBPROVIDER - IRF	0	6,250		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	345,585		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-870,107	1,021,473		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-189,592	2,376,936		54.00
60.00	06000	LABORATORY	0	1,888,988		60.00
65.00	06500	RESPIRATORY THERAPY	0	424,002		65.00
66.00	06600	PHYSICAL THERAPY	-27,770	470,513		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	201,436		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	291,929		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-590,239	1,413,699		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04050	CLINIC	-4,092,586	1,961,045		93.00
93.01	04950	BIC	-6,942	14,259		93.01
93.05	04954	PODIATRY	0	0		93.05
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-3,443	-3,443		95.00
101.00	10100	HOME HEALTH AGENCY	0	39,357		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	5,011		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,004,279	35,275,619		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
191.01	19101	FMH DIAGNOSTIC CENTER	0	99,974		191.01
191.02	19102	WELLNESS	0	186,535		191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	19,040		192.00
192.01	19201	RFE	0	1,998		192.01
192.02	19202	MARKETING	0	176,465		192.02
192.03	19203	FOUNDATION	0	0		192.03
192.06	19206	HEART CENTER	0	0		192.06
192.07	19207	WVCP	0	2,438,563		192.07
192.08	19208	OCCUPATIONAL MED	0	3,190		192.08
192.10	19210	HOSPITALIST	0	1,169,519		192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	1,644		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,004,279	39,372,547		200.00

RECLASSIFICATIONS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 10:28 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	314,661	210,151		1.00
	0		314,661	210,151		
	B - NURSERY					
1.00	NURSERY	43.00	271,312	74,273		1.00
	0		271,312	74,273		
	C - COACH RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	168,320	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	212,287	0		2.00
3.00	OPERATION OF PLANT	7.00	10,886	0		3.00
4.00	HOUSEKEEPING	9.00	23,239	0		4.00
5.00	DIETARY	10.00	22,942	0		5.00
6.00	NURSING ADMINISTRATION	13.00	14,624	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	3,662	0		7.00
8.00	PHARMACY	15.00	5,914	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	74,380	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	21,769	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	15,136	0		11.00
12.00	SUBPROVIDER - IPF	40.00	3,120	0		12.00
13.00	OPERATING ROOM	50.00	12,101	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	36,042	0		14.00
15.00	LABORATORY	60.00	27,863	0		15.00
16.00	RESPIRATORY THERAPY	65.00	6,575	0		16.00
17.00	PHYSICAL THERAPY	66.00	9,519	0		17.00
18.00	CARDIAC REHAB	69.01	3,487	0		18.00
19.00	EMERGENCY	91.00	22,517	0		19.00
20.00	CLINIC	93.00	88,949	0		20.00
21.00	BIC	93.01	185	0		21.00
22.00	HOME HEALTH AGENCY	101.00	438	0		22.00
23.00	FMH DIAGNOSTIC CENTER	191.01	3,412	0		23.00
24.00	WELLNESS	191.02	1,590	0		24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,883	0		25.00
26.00	MARKETING	192.02	1,278	0		26.00
27.00	WVCP	192.07	38,657	0		27.00
28.00	HOSPITALIST	192.10	5,500	0		28.00
	0		836,275	0		
	D - MARKETING					
1.00	ADMINISTRATIVE & GENERAL	5.00	9,686	20,985		1.00
	0		9,686	20,985		
	E - HOSPICE					
1.00	HOSPICE	116.00	164	0		1.00
	0		164	0		
	F - HOSPITAL UTILITIES					
1.00	OPERATION OF PLANT	7.01	0	916,991		1.00
	0		0	916,991		
	G - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	291,929		1.00
	0		0	291,929		
500.00	Grand Total: Increases		1,432,098	1,514,329		500.00

RECLASSIFICATIONS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 10:28 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	314,661	210,151	0	1.00
	0		314,661	210,151		
	B - NURSERY					
1.00	ADULTS & PEDIATRICS	30.00	271,312	74,273	0	1.00
	0		271,312	74,273		
	C - COACH RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	836,275	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
	0		836,275	0		
	D - MARKETING					
1.00	MARKETING	192.02	9,686	20,985	0	1.00
	0		9,686	20,985		
	E - HOSPICE					
1.00	HOME HEALTH AGENCY	101.00	164	0	0	1.00
	0		164	0		
	F - HOSPITAL UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	916,991	0	1.00
	0		0	916,991		
	G - IMPLANTABLE DEVICES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	291,929	0	1.00
	0		0	291,929		
500.00	Grand Total: Decreases		1,432,098	1,514,329		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2018 10:28 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,094,402	0	0	0	90,677	1.00
2.00	Land Improvements	520,578	14,779	0	14,779	63,991	2.00
3.00	Buildings and Fixtures	50,749,199	1,278,291	0	1,278,291	707,006	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	24,531,616	657,280	0	657,280	2,207,026	5.00
6.00	Movable Equipment	35,713	1,108,266	0	1,108,266	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,931,508	3,058,616	0	3,058,616	3,068,700	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,931,508	3,058,616	0	3,058,616	3,068,700	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,003,725	0	1.00
2.00	Land Improvements	471,366	0	2.00
3.00	Buildings and Fixtures	51,320,484	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	22,981,870	0	5.00
6.00	Movable Equipment	1,143,979	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,921,424	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	76,921,424	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2018 10:28 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	44,886	0	2,217,124	0	0	1.00
3.00	Total (sum of lines 1-2)	44,886	0	2,217,124	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,262,010		1.00
3.00	Total (sum of lines 1-2)	0	2,262,010		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2018 10:28 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	51,320,484	0	51,320,484	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	51,320,484	0	51,320,484	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	34,965	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	34,965	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,204,602	0	0	0	2,239,567	1.00
3.00	Total (sum of lines 1-2)	2,204,602	0	0	0	2,239,567	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 10:28 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** 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	-5,159,227			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	A	-9,248	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** 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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INTEREST OFFSET	B	-12,522	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 10:28 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	
33.02	PFS BILLING SVC -OTHER REV	B	-135	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	VENDOR REBATE/REFUND-OTHER REV	B	-107,528	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PURCHASE DISC EARNED-OTHER REV	B	15,138	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	COLLEDTION FEES REV-OTHER REV	B	-3,072	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	CAFETERIA SALES-OTHER REV	B	-213,183	CAFETERIA	11.00	0	33.06
33.07	CAF VEND MACHIN-OTHER REV	B	-1,182	CAFETERIA	11.00	0	33.07
33.08	EDUCATION & TRAINING-OTHER REV	B	-55	NURSING ADMINISTRATION	13.00	0	33.08
33.09	EMPLOYEE DRUG SALES-OTHER REV	B	-9,442	PHARMACY	15.00	0	33.09
33.10	PHY TH SCHOOL REV-OTHER REV	B	-27,770	PHYSICAL THERAPY	66.00	0	33.10
33.11	HELPLINE -OTHER REV	B	-3,443	AMBULANCE SERVICES	95.00	0	33.11
33.12	IHA DUES	A	-1,031	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	TELEVISION	A	-2,641	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	TELEVISION ELECTRICITY	A	-382	OPERATION OF PLANT	7.00	0	33.14
33.15	24TH ST DEPRECIATION	A	-9,921	CAP REL COSTS-BLDG & FIXT	1.00	9	33.15
33.16	PHYSICIAN RECRUITMENT	A	-78,259	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	340B REVENUE	A	-2,719,437	PHARMACY	15.00	0	33.17
33.18	ER PURCHASED SERVICES	A	-590,239	EMERGENCY	91.00	0	33.18
33.19	HAF OFFSET	A	-1,070,700	ADMINISTRATIVE & GENERAL	5.00	0	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,004,279				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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2018 10:28 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	93.00	CLINIC	3,437,329	3,145,403	291,926	179,000	1,632	1.00
2.00	93.01	BIC	6,942	6,942	0	0	0	2.00
3.00	50.00	OPERATING ROOM	870,107	870,107	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	189,592	189,592	0	0	0	4.00
5.00	93.00	CLINIC	795,703	795,703	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,299,673	5,007,747	291,926		1,632	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	93.00	CLINIC	140,446	7,022	0	0	0	1.00
2.00	93.01	BIC	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	93.00	CLINIC	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			140,446	7,022	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	93.00	CLINIC	0	140,446	151,480	3,296,883		1.00
2.00	93.01	BIC	0	0	0	6,942		2.00
3.00	50.00	OPERATING ROOM	0	0	0	870,107		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	189,592		4.00
5.00	93.00	CLINIC	0	0	0	795,703		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	140,446	151,480	5,159,227		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,239,567	2,239,567				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,576,688	8,898	4,585,586			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,903,584	144,096	376,321	6,424,001	6,424,001	5.00
7.00	00700	OPERATION OF PLANT	1,630,052	958,427	69,142	2,657,621	518,103	7.00
7.01	00701	OPERATION OF PLANT	916,991	0	0	916,991	178,767	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	124,496	2,746	0	127,242	24,806	8.00
9.00	00900	HOUSEKEEPING	639,878	11,303	132,479	783,660	152,775	9.00
10.00	01000	DIETARY	384,453	15,789	58,860	459,102	89,502	10.00
11.00	01100	CAFETERIA	310,447	22,914	77,270	410,631	80,053	11.00
13.00	01300	NURSING ADMINISTRATION	714,443	0	174,760	889,203	173,350	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	807,104	15,028	18,422	840,554	163,866	14.00
15.00	01500	PHARMACY	2,368,219	14,542	78,136	2,460,897	479,752	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	899,976	21,796	183,843	1,105,615	215,540	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,056,870	127,854	218,789	1,403,513	273,615	30.00
31.00	03100	INTENSIVE CARE UNIT	704,988	51,964	150,344	907,296	176,877	31.00
40.00	04000	SUBPROVIDER - IPF	1,540,823	44,156	199,300	1,784,279	347,845	40.00
41.00	04100	SUBPROVIDER - IRF	6,250	0	0	6,250	1,218	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	345,585	26,074	66,625	438,284	85,443	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,021,473	138,704	154,787	1,314,964	256,352	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,376,936	123,424	239,229	2,739,589	534,083	54.00
60.00	06000	LABORATORY	1,888,988	39,933	166,924	2,095,845	408,585	60.00
65.00	06500	RESPIRATORY THERAPY	424,002	20,056	91,627	535,685	104,432	65.00
66.00	06600	PHYSICAL THERAPY	470,513	43,407	118,699	632,619	123,329	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	201,436	16,678	46,080	264,194	51,505	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	291,929	0	0	291,929	56,912	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,413,699	47,596	293,230	1,754,525	342,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04050	CLINIC	1,961,045	144,308	1,095,734	3,201,087	624,061	93.00
93.01	04950	BIC	14,259	0	45	14,304	2,789	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	-3,443	0	0	-3,443	0	95.00
101.00	10100	HOME HEALTH AGENCY	39,357	0	5,998	45,355	8,842	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	5,011	0	40	5,051	985	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,275,619	2,039,693	4,016,684	34,506,843	5,475,432	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTER	99,974	0	22,846	122,820	23,944	191.01
191.02	19102	WELLNESS	186,535	0	20,790	207,325	40,418	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,040	6,924	3,146	29,110	5,675	192.00
192.01	19201	RFE	1,998	0	0	1,998	390	192.01
192.02	19202	MARKETING	176,465	7,299	13,899	197,663	38,534	192.02
192.03	19203	FOUNDATION	0	7,886	0	7,886	1,537	192.03
192.06	19206	HEART CENTER	0	5,274	0	5,274	1,028	192.06
192.07	19207	WVCP	2,438,563	117,921	437,946	2,994,430	583,764	192.07
192.08	19208	OCCUPATIONAL MED	3,190	0	0	3,190	622	192.08
192.10	19210	HOSPITALIST	1,169,519	0	70,275	1,239,794	241,698	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,644	54,570	0	56,214	10,959	194.00
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)	39,372,547	2,239,567	4,585,586	39,372,547	6,424,001	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	3,175,724					7.00
7.01	00701	OPERATION OF PLANT	0	1,095,758				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	7,397	3,709	163,154			8.00
9.00	00900	HOUSEKEEPING	30,446	15,268	0	982,149		9.00
10.00	01000	DIETARY	42,528	21,327	17,585	13,594	643,638	10.00
11.00	01100	CAFETERIA	61,721	30,951	0	19,728	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40,479	20,299	0	12,939	0	14.00
15.00	01500	PHARMACY	39,169	19,642	0	12,520	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,708	29,440	0	18,765	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	344,383	172,698	41,392	110,077	234,787	30.00
31.00	03100	INTENSIVE CARE UNIT	139,968	70,190	15,093	44,739	42,618	31.00
40.00	04000	SUBPROVIDER - IPF	118,937	0	0	38,017	70,453	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	70,233	35,220	0	22,449	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	373,609	187,354	14,789	119,419	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	332,452	166,715	21,921	106,264	0	54.00
60.00	06000	LABORATORY	107,563	53,940	0	34,381	0	60.00
65.00	06500	RESPIRATORY THERAPY	54,023	27,091	0	17,268	0	65.00
66.00	06600	PHYSICAL THERAPY	116,919	58,631	18,808	37,371	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	44,924	22,528	1,380	14,359	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	128,202	64,290	28,925	40,978	15,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04050	CLINIC	388,705	59,477	103	124,243	0	93.00
93.01	04950	BIC	0	0	0	0	0	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,500,366	1,058,770	159,996	787,111	363,302	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTER	0	0	0	0	0	191.01
191.02	19102	WELLNESS	136,985	0	0	43,785	0	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,650	9,353	2,629	5,961	0	192.00
192.01	19201	RFE	0	0	0	0	0	192.01
192.02	19202	MARKETING	19,660	9,859	0	6,284	0	192.02
192.03	19203	FOUNDATION	21,241	10,652	0	6,790	0	192.03
192.06	19206	HEART CENTER	14,206	7,124	0	4,541	0	192.06
192.07	19207	WVCP	317,628	0	529	99,893	280,336	192.07
192.08	19208	OCCUPATIONAL MED	0	0	0	0	0	192.08
192.10	19210	HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	146,988	0	0	27,784	0	194.00
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)	3,175,724	1,095,758	163,154	982,149	643,638	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
7.01	00701	OPERATION OF PLANT						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	603,084					11.00
13.00	01300	NURSING ADMINISTRATION	19,539	1,082,092				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,685	0	1,082,822			14.00
15.00	01500	PHARMACY	11,591	45,889	0	3,069,460		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,926	0	0	0	1,463,994	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,620	149,013	0	0	63,977	30.00
31.00	03100	INTENSIVE CARE UNIT	26,310	104,238	0	0	16,458	31.00
40.00	04000	SUBPROVIDER - IPF	36,740	145,569	0	0	66,820	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	17	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	9,428	37,380	0	0	6,064	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,363	104,441	0	0	92,877	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,581	156,814	0	0	346,659	54.00
60.00	06000	LABORATORY	36,194	143,340	0	0	265,047	60.00
65.00	06500	RESPIRATORY THERAPY	17,821	70,606	0	0	51,021	65.00
66.00	06600	PHYSICAL THERAPY	19,765	78,305	0	0	29,474	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	9,187	36,367	0	0	7,198	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,082,822	0	35,911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,022	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,069,460	151,929	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	47,751	0	0	0	228,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04050	CLINIC	101,829	0	0	0	91,712	93.00
93.01	04950	BIC	0	0	0	0	33	93.01
93.05	04954	PODIATRY	0	0	0	0	8	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,556	10,130	0	0	300	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	291	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	482,886	1,082,092	1,082,822	3,069,460	1,463,994	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTER	0	0	0	0	0	191.01
191.02	19102	WELLNESS	0	0	0	0	0	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RFE	0	0	0	0	0	192.01
192.02	19202	MARKETING	2,053	0	0	0	0	192.02
192.03	19203	FOUNDATION	2,292	0	0	0	0	192.03
192.06	19206	HEART CENTER	0	0	0	0	0	192.06
192.07	19207	WVCP	113,286	0	0	0	0	192.07
192.08	19208	OCCUPATIONAL MED	0	0	0	0	0	192.08
192.10	19210	HOSPITALIST	2,567	0	0	0	0	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	603,084	1,082,092	1,082,822	3,069,460	1,463,994	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,831,075	0	2,831,075		30.00
31.00	03100	INTENSIVE CARE UNIT	1,543,787	0	1,543,787		31.00
40.00	04000	SUBPROVIDER - IPF	2,608,660	0	2,608,660		40.00
41.00	04100	SUBPROVIDER - IRF	7,485	0	7,485		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	704,501	0	704,501		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,490,168	0	2,490,168		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,444,078	0	4,444,078		54.00
60.00	06000	LABORATORY	3,144,895	0	3,144,895		60.00
65.00	06500	RESPIRATORY THERAPY	877,947	0	877,947		65.00
66.00	06600	PHYSICAL THERAPY	1,115,221	0	1,115,221		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHAB	451,642	0	451,642		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,118,733	0	1,118,733		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	358,863	0	358,863		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,221,389	0	3,221,389		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,650,336	0	2,650,336		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04050	CLINIC	4,591,217	0	4,591,217		93.00
93.01	04950	BIC	17,126	0	17,126		93.01
93.05	04954	PODIATRY	8	0	8		93.05
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-3,443	0	-3,443		95.00
101.00	10100	HOME HEALTH AGENCY	67,183	0	67,183		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	6,327	0	6,327		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,247,198	0	32,247,198		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
191.01	19101	FMH DIAGNOSTIC CENTER	146,764	0	146,764		191.01
191.02	19102	WELLNESS	428,513	0	428,513		191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	71,378	0	71,378		192.00
192.01	19201	RFE	2,388	0	2,388		192.01
192.02	19202	MARKETING	274,053	0	274,053		192.02
192.03	19203	FOUNDATION	50,398	0	50,398		192.03
192.06	19206	HEART CENTER	32,173	0	32,173		192.06
192.07	19207	WVCP	4,389,866	0	4,389,866		192.07
192.08	19208	OCCUPATIONAL MED	3,812	0	3,812		192.08
192.10	19210	HOSPITALIST	1,484,059	0	1,484,059		192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	241,945	0	241,945		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	39,372,547	0	39,372,547		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,898	8,898	8,898		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	144,096	144,096	731	144,827	5.00
7.00	00700	OPERATION OF PLANT	0	958,427	958,427	134	11,680	7.00
7.01	00701	OPERATION OF PLANT	0	0	0	0	4,030	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,746	2,746	0	559	8.00
9.00	00900	HOUSEKEEPING	0	11,303	11,303	257	3,444	9.00
10.00	01000	DIETARY	0	15,789	15,789	114	2,018	10.00
11.00	01100	CAFETERIA	0	22,914	22,914	150	1,805	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	339	3,908	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,028	15,028	36	3,694	14.00
15.00	01500	PHARMACY	0	14,542	14,542	152	10,816	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,796	21,796	357	4,859	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	127,854	127,854	425	6,168	30.00
31.00	03100	INTENSIVE CARE UNIT	0	51,964	51,964	292	3,988	31.00
40.00	04000	SUBPROVIDER - IPF	0	44,156	44,156	387	7,842	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	27	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	26,074	26,074	129	1,926	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	138,704	138,704	301	5,779	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	123,424	123,424	465	12,040	54.00
60.00	06000	LABORATORY	0	39,933	39,933	324	9,211	60.00
65.00	06500	RESPIRATORY THERAPY	0	20,056	20,056	178	2,354	65.00
66.00	06600	PHYSICAL THERAPY	0	43,407	43,407	231	2,780	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	16,678	16,678	90	1,161	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,283	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	47,596	47,596	570	7,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04050	CLINIC	0	144,308	144,308	2,119	14,074	93.00
93.01	04950	BIC	0	0	0	0	63	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	12	199	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	22	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,039,693	2,039,693	7,793	123,441	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTER	0	0	0	44	540	191.01
191.02	19102	WELLNESS	0	0	0	40	911	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,924	6,924	6	128	192.00
192.01	19201	RFE	0	0	0	0	9	192.01
192.02	19202	MARKETING	0	7,299	7,299	27	869	192.02
192.03	19203	FOUNDATION	0	7,886	7,886	0	35	192.03
192.06	19206	HEART CENTER	0	5,274	5,274	0	23	192.06
192.07	19207	WVCP	0	117,921	117,921	851	13,161	192.07
192.08	19208	OCCUPATIONAL MED	0	0	0	0	14	192.08
192.10	19210	HOSPITALIST	0	0	0	137	5,449	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	54,570	54,570	0	247	194.00
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	2,239,567	2,239,567	8,898	144,827	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	970,241					7.00
7.01	00701	OPERATION OF PLANT	0	4,030				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,260	14	5,579			8.00
9.00	00900	HOUSEKEEPING	9,302	56	0	24,362		9.00
10.00	01000	DIETARY	12,993	78	601	337	31,930	10.00
11.00	01100	CAFETERIA	18,857	114	0	489	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,367	75	0	321	0	14.00
15.00	01500	PHARMACY	11,967	72	0	311	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,936	108	0	465	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	105,215	635	1,415	2,730	11,647	30.00
31.00	03100	INTENSIVE CARE UNIT	42,763	258	516	1,110	2,114	31.00
40.00	04000	SUBPROVIDER - IPF	36,337	0	0	943	3,495	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	21,457	130	0	557	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	114,144	690	506	2,962	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,570	613	750	2,636	0	54.00
60.00	06000	LABORATORY	32,863	198	0	853	0	60.00
65.00	06500	RESPIRATORY THERAPY	16,505	100	0	428	0	65.00
66.00	06600	PHYSICAL THERAPY	35,721	216	643	927	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	13,725	83	47	356	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	39,168	236	989	1,016	766	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04050	CLINIC	118,757	219	4	3,083	0	93.00
93.01	04950	BIC	0	0	0	0	0	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	763,907	3,895	5,471	19,524	18,022	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTER	0	0	0	0	0	191.01
191.02	19102	WELLNESS	41,851	0	0	1,086	0	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,698	34	90	148	0	192.00
192.01	19201	RFE	0	0	0	0	0	192.01
192.02	19202	MARKETING	6,006	36	0	156	0	192.02
192.03	19203	FOUNDATION	6,490	39	0	168	0	192.03
192.06	19206	HEART CENTER	4,340	26	0	113	0	192.06
192.07	19207	WVCP	97,041	0	18	2,478	13,908	192.07
192.08	19208	OCCUPATIONAL MED	0	0	0	0	0	192.08
192.10	19210	HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	44,908	0	0	689	0	194.00
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)	970,241	4,030	5,579	24,362	31,930	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
7.01	00701	OPERATION OF PLANT						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	44,329					11.00
13.00	01300	NURSING ADMINISTRATION	1,436	5,683				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	344	0	31,865			14.00
15.00	01500	PHARMACY	852	241	0	38,953		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,641	0	0	0	48,162	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,765	783	0	0	2,103	30.00
31.00	03100	INTENSIVE CARE UNIT	1,934	547	0	0	541	31.00
40.00	04000	SUBPROVIDER - IPF	2,701	765	0	0	2,196	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	1	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	693	196	0	0	199	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,938	549	0	0	3,053	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,909	823	0	0	11,439	54.00
60.00	06000	LABORATORY	2,660	753	0	0	8,711	60.00
65.00	06500	RESPIRATORY THERAPY	1,310	371	0	0	1,677	65.00
66.00	06600	PHYSICAL THERAPY	1,453	411	0	0	969	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	675	191	0	0	237	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	31,865	0	1,180	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	329	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,953	4,993	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,510	0	0	0	7,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04050	CLINIC	7,485	0	0	0	3,014	93.00
93.01	04950	BIC	0	0	0	0	1	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	188	53	0	0	10	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	10	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,494	5,683	31,865	38,953	48,162	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTER	0	0	0	0	0	191.01
191.02	19102	WELLNESS	0	0	0	0	0	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RFE	0	0	0	0	0	192.01
192.02	19202	MARKETING	151	0	0	0	0	192.02
192.03	19203	FOUNDATION	168	0	0	0	0	192.03
192.06	19206	HEART CENTER	0	0	0	0	0	192.06
192.07	19207	WVCP	8,327	0	0	0	0	192.07
192.08	19208	OCCUPATIONAL MED	0	0	0	0	0	192.08
192.10	19210	HOSPITALIST	189	0	0	0	0	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	44,329	5,683	31,865	38,953	48,162	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	261,740	0	261,740		30.00
31.00	03100	INTENSIVE CARE UNIT	106,027	0	106,027		31.00
40.00	04000	SUBPROVIDER - IPF	98,822	0	98,822		40.00
41.00	04100	SUBPROVIDER - IRF	28	0	28		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	51,361	0	51,361		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	268,626	0	268,626		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,669	0	256,669		54.00
60.00	06000	LABORATORY	95,506	0	95,506		60.00
65.00	06500	RESPIRATORY THERAPY	42,979	0	42,979		65.00
66.00	06600	PHYSICAL THERAPY	86,758	0	86,758		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHAB	33,243	0	33,243		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,045	0	33,045		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,612	0	1,612		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,946	0	43,946		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	109,061	0	109,061		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04050	CLINIC	293,063	0	293,063		93.00
93.01	04950	BIC	64	0	64		93.01
93.05	04954	PODIATRY	0	0	0		93.05
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	462	0	462		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	32	0	32		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,783,044	0	1,783,044		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
191.01	19101	FMH DIAGNOSTIC CENTER	584	0	584		191.01
191.02	19102	WELLNESS	43,888	0	43,888		191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,028	0	13,028		192.00
192.01	19201	RFE	9	0	9		192.01
192.02	19202	MARKETING	14,544	0	14,544		192.02
192.03	19203	FOUNDATION	14,786	0	14,786		192.03
192.06	19206	HEART CENTER	9,776	0	9,776		192.06
192.07	19207	WVCP	253,705	0	253,705		192.07
192.08	19208	OCCUPATIONAL MED	14	0	14		192.08
192.10	19210	HOSPITALIST	5,775	0	5,775		192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	100,414	0	100,414		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,239,567	0	2,239,567		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	CAPITAL RELATED COSTS 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	CAP REL COSTS-BLDG & FIXT	400,430					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,591	18,673,601				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,764	1,532,471	-6,424,001	32,951,989		5.00
7.00	00700	OPERATION OF PLANT	171,365	281,564	0	2,657,621	210,803	7.00
7.01	00701	OPERATION OF PLANT	0	0	0	916,991	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	491	0	0	127,242	491	8.00
9.00	00900	HOUSEKEEPING	2,021	539,488	0	783,660	2,021	9.00
10.00	01000	DIETARY	2,823	239,693	0	459,102	2,823	10.00
11.00	01100	CAFETERIA	4,097	314,661	0	410,631	4,097	11.00
13.00	01300	NURSING ADMINISTRATION	0	711,663	0	889,203	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,687	75,020	0	840,554	2,687	14.00
15.00	01500	PHARMACY	2,600	318,190	0	2,460,897	2,600	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,897	748,652	0	1,105,615	3,897	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,860	890,963	0	1,403,513	22,860	30.00
31.00	03100	INTENSIVE CARE UNIT	9,291	612,238	0	907,296	9,291	31.00
40.00	04000	SUBPROVIDER - IPF	7,895	811,596	0	1,784,279	7,895	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	6,250	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	4,662	271,312	0	438,284	4,662	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,800	630,332	0	1,314,964	24,800	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,068	974,200	0	2,739,589	22,068	54.00
60.00	06000	LABORATORY	7,140	679,753	0	2,095,845	7,140	60.00
65.00	06500	RESPIRATORY THERAPY	3,586	373,129	0	535,685	3,586	65.00
66.00	06600	PHYSICAL THERAPY	7,761	483,372	0	632,619	7,761	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	2,982	187,649	0	264,194	2,982	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	291,929	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,510	1,194,104	0	1,754,525	8,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04050	CLINIC	25,802	4,462,071	0	3,201,087	25,802	93.00
93.01	04950	BIC	0	185	0	14,304	0	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	3,443	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	24,425	0	45,355	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	164	0	5,051	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	364,693	16,356,895	-6,420,558	28,086,285	165,973	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTER	0	93,033	0	122,820	0	191.01
191.02	19102	WELLNESS	0	84,663	0	207,325	9,093	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,238	12,810	0	29,110	1,238	192.00
192.01	19201	RFE	0	0	0	1,998	0	192.01
192.02	19202	MARKETING	1,305	56,602	0	197,663	1,305	192.02
192.03	19203	FOUNDATION	1,410	0	0	7,886	1,410	192.03
192.06	19206	HEART CENTER	943	0	0	5,274	943	192.06
192.07	19207	WVCP	21,084	1,783,422	0	2,994,430	21,084	192.07
192.08	19208	OCCUPATIONAL MED	0	0	0	3,190	0	192.08
192.10	19210	HOSPITALIST	0	286,176	0	1,239,794	0	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	9,757	0	0	56,214	9,757	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,239,567	4,585,586		6,424,001	3,175,724	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.592905	0.245565		0.194950	15.064890	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		8,898		144,827	970,241	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000477		0.004395	4.602596	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
7.01	00701	OPERATION OF PLANT	145,045					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	491	63,248				8.00
9.00	00900	HOUSEKEEPING	2,021	0	203,965			9.00
10.00	01000	DIETARY	2,823	6,817	2,823	62,388		10.00
11.00	01100	CAFETERIA	4,097	0	4,097	0	490,557	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	15,893	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,687	0	2,687	0	3,811	14.00
15.00	01500	PHARMACY	2,600	0	2,600	0	9,428	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,897	0	3,897	0	29,223	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,860	16,046	22,860	22,758	30,601	30.00
31.00	03100	INTENSIVE CARE UNIT	9,291	5,851	9,291	4,131	21,401	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	7,895	6,829	29,885	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	4,662	0	4,662	0	7,669	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,800	5,733	24,800	0	21,444	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,068	8,498	22,068	0	32,196	54.00
60.00	06000	LABORATORY	7,140	0	7,140	0	29,441	60.00
65.00	06500	RESPIRATORY THERAPY	3,586	0	3,586	0	14,496	65.00
66.00	06600	PHYSICAL THERAPY	7,761	7,291	7,761	0	16,077	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	2,982	535	2,982	0	7,473	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,510	11,213	8,510	1,497	38,841	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04050	CLINIC	7,873	40	25,802	0	82,829	93.00
93.01	04950	BIC	0	0	0	0	0	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	2,079	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,149	62,024	163,461	35,215	392,787	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTER	0	0	0	0	0	191.01
191.02	19102	WELLNESS	0	0	9,093	0	0	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,238	1,019	1,238	0	0	192.00
192.01	19201	RFE	0	0	0	0	0	192.01
192.02	19202	MARKETING	1,305	0	1,305	0	1,670	192.02
192.03	19203	FOUNDATION	1,410	0	1,410	0	1,864	192.03
192.06	19206	HEART CENTER	943	0	943	0	0	192.06
192.07	19207	WVCP	0	205	20,745	27,173	92,148	192.07
192.08	19208	OCCUPATIONAL MED	0	0	0	0	0	192.08
192.10	19210	HOSPITALIST	0	0	0	0	2,088	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	5,770	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,095,758	163,154	982,149	643,638	603,084	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.554607	2.579591	4.815282	10.316696	1.229386	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,030	5,579	24,362	31,930	44,329	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.027784	0.088208	0.119442	0.511797	0.090365	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 10:28 am

		Cost Center Description	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
7.01	00701	OPERATION OF PLANT						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	10,682					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	453	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	93,067,932		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,471	0	0	4,067,183		30.00
31.00	03100	INTENSIVE CARE UNIT	1,029	0	0	1,046,311		31.00
40.00	04000	SUBPROVIDER - IPF	1,437	0	0	4,247,965		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	1,087		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	369	0	0	385,517		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,031	0	0	5,904,468		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,548	0	0	22,035,714		54.00
60.00	06000	LABORATORY	1,415	0	0	16,849,765		60.00
65.00	06500	RESPIRATORY THERAPY	697	0	0	3,243,536		65.00
66.00	06600	PHYSICAL THERAPY	773	0	0	1,873,713		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	06901	CARDIAC REHAB	359	0	0	457,603		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	2,282,933		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	637,133		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	9,658,580		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	14,505,769		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04050	CLINIC	0	0	0	5,830,412		93.00
93.01	04950	BIC	0	0	0	2,108		93.01
93.05	04954	PODIATRY	0	0	0	536		93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	100	0	0	19,071		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	18,528		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,682	100	100	93,067,932		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
191.01	19101	FMH DIAGNOSTIC CENTER	0	0	0	0		191.01
191.02	19102	WELLNESS	0	0	0	0		191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	RFE	0	0	0	0		192.01
192.02	19202	MARKETING	0	0	0	0		192.02
192.03	19203	FOUNDATION	0	0	0	0		192.03
192.06	19206	HEART CENTER	0	0	0	0		192.06
192.07	19207	WVCP	0	0	0	0		192.07
192.08	19208	OCCUPATIONAL MED	0	0	0	0		192.08
192.10	19210	HOSPITALIST	0	0	0	0		192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,082,092	1,082,822	3,069,460	1,463,994		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	101.300506	10,828.220000	30,694.600000	0.015730		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,683	31,865	38,953	48,162		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.532016	318.650000	389.530000	0.000517		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 10:28 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	2,831,075		2,831,075	0	2,831,075	30.00
31.00	03100	INTENSIVE CARE UNIT	1,543,787		1,543,787	0	1,543,787	31.00
40.00	04000	SUBPROVIDER - IPF	2,608,660		2,608,660	0	2,608,660	40.00
41.00	04100	SUBPROVIDER - IRF	7,485		7,485	0	7,485	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	704,501		704,501	0	704,501	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,490,168		2,490,168	0	2,490,168	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,444,078		4,444,078	0	4,444,078	54.00
60.00	06000	LABORATORY	3,144,895		3,144,895	0	3,144,895	60.00
65.00	06500	RESPIRATORY THERAPY	877,947	0	877,947	0	877,947	65.00
66.00	06600	PHYSICAL THERAPY	1,115,221	0	1,115,221	0	1,115,221	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIAC REHAB	451,642		451,642	0	451,642	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,118,733		1,118,733	0	1,118,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	358,863		358,863	0	358,863	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,221,389		3,221,389	0	3,221,389	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,650,336		2,650,336	0	2,650,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	616,706		616,706		616,706	92.00
93.00	04050	CLINIC	4,591,217		4,591,217	151,480	4,742,697	93.00
93.01	04950	BIC	17,126		17,126	0	17,126	93.01
93.05	04954	PODIATRY	8		8	0	8	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	67,183		67,183		67,183	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	6,327		6,327		6,327	116.00
200.00		Subtotal (see instructions)	32,867,347	0	32,867,347	151,480	33,018,827	200.00
201.00		Less Observation Beds	616,706		616,706		616,706	201.00
202.00		Total (see instructions)	32,250,641	0	32,250,641	151,480	32,402,121	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,397,787		3,397,787			30.00
31.00	03100	INTENSIVE CARE UNIT	1,046,311		1,046,311			31.00
40.00	04000	SUBPROVIDER - IPF	4,247,965		4,247,965			40.00
41.00	04100	SUBPROVIDER - IRF	1,087		1,087			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	385,517		385,517			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	859,671	5,044,797	5,904,468	0.421743	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,105,005	20,930,709	22,035,714	0.201676	0.000000	54.00
60.00	06000	LABORATORY	2,264,650	14,585,115	16,849,765	0.186643	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	805,095	2,438,441	3,243,536	0.270676	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	245,093	1,628,620	1,873,713	0.595193	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	457,603	457,603	0.986973	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	606,828	1,676,105	2,282,933	0.490042	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,732	621,401	637,133	0.563247	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,383,348	7,275,232	9,658,580	0.333526	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	899,503	13,606,266	14,505,769	0.182709	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	669,396	669,396	0.921287	0.000000	92.00
93.00	04050	CLINIC	429	5,829,983	5,830,412	0.787460	0.000000	93.00
93.01	04950	BIC	0	2,108	2,108	8.124288	0.000000	93.01
93.05	04954	PODIATRY	0	536	536	0.014925	0.000000	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	19,071	19,071			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	18,528	18,528			116.00
200.00		Subtotal (see instructions)	18,264,021	74,803,911	93,067,932			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,264,021	74,803,911	93,067,932			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 10:28 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
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.421743	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201676	54.00
60.00	06000	LABORATORY	0.186643	60.00
65.00	06500	RESPIRATORY THERAPY	0.270676	65.00
66.00	06600	PHYSICAL THERAPY	0.595193	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIAC REHAB	0.986973	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.490042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.563247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333526	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.182709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.921287	92.00
93.00	04050	CLINIC	0.813441	93.00
93.01	04950	BIC	8.124288	93.01
93.05	04954	PODIATRY	0.014925	93.05
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 10:28 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	2,831,075		2,831,075	0	2,831,075	30.00
31.00	03100	INTENSIVE CARE UNIT	1,543,787		1,543,787	0	1,543,787	31.00
40.00	04000	SUBPROVIDER - IPF	2,608,660		2,608,660	0	2,608,660	40.00
41.00	04100	SUBPROVIDER - IRF	7,485		7,485	0	7,485	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	704,501		704,501	0	704,501	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,490,168		2,490,168	0	2,490,168	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,444,078		4,444,078	0	4,444,078	54.00
60.00	06000	LABORATORY	3,144,895		3,144,895	0	3,144,895	60.00
65.00	06500	RESPIRATORY THERAPY	877,947	0	877,947	0	877,947	65.00
66.00	06600	PHYSICAL THERAPY	1,115,221	0	1,115,221	0	1,115,221	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIAC REHAB	451,642		451,642	0	451,642	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,118,733		1,118,733	0	1,118,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	358,863		358,863	0	358,863	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,221,389		3,221,389	0	3,221,389	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,650,336		2,650,336	0	2,650,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	616,706		616,706		616,706	92.00
93.00	04050	CLINIC	4,591,217		4,591,217	151,480	4,742,697	93.00
93.01	04950	BIC	17,126		17,126	0	17,126	93.01
93.05	04954	PODIATRY	8		8	0	8	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	67,183		67,183		67,183	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	6,327		6,327		6,327	116.00
200.00		Subtotal (see instructions)	32,867,347	0	32,867,347	151,480	33,018,827	200.00
201.00		Less Observation Beds	616,706		616,706		616,706	201.00
202.00		Total (see instructions)	32,250,641	0	32,250,641	151,480	32,402,121	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 10:28 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,397,787		3,397,787			30.00
31.00	03100	INTENSIVE CARE UNIT	1,046,311		1,046,311			31.00
40.00	04000	SUBPROVIDER - IPF	4,247,965		4,247,965			40.00
41.00	04100	SUBPROVIDER - IRF	1,087		1,087			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	385,517		385,517			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	859,671	5,044,797	5,904,468	0.421743	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,105,005	20,930,709	22,035,714	0.201676	0.000000	54.00
60.00	06000	LABORATORY	2,264,650	14,585,115	16,849,765	0.186643	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	805,095	2,438,441	3,243,536	0.270676	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	245,093	1,628,620	1,873,713	0.595193	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	457,603	457,603	0.986973	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	606,828	1,676,105	2,282,933	0.490042	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,732	621,401	637,133	0.563247	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,383,348	7,275,232	9,658,580	0.333526	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	899,503	13,606,266	14,505,769	0.182709	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	669,396	669,396	0.921287	0.000000	92.00
93.00	04050	CLINIC	429	5,829,983	5,830,412	0.787460	0.000000	93.00
93.01	04950	BIC	0	2,108	2,108	8.124288	0.000000	93.01
93.05	04954	PODIATRY	0	536	536	0.014925	0.000000	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	19,071	19,071			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	18,528	18,528			116.00
200.00		Subtotal (see instructions)	18,264,021	74,803,911	93,067,932			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,264,021	74,803,911	93,067,932			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 10:28 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
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04050	CLINIC	0.000000		93.00
93.01	04950	BIC	0.000000		93.01
93.05	04954	PODIATRY	0.000000		93.05
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/26/2018 10:28 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	261,740	0	261,740	2,254	116.12	30.00
31.00	INTENSIVE CARE UNIT	106,027		106,027	271	391.24	31.00
40.00	SUBPROVIDER - IPF	98,822	0	98,822	2,242	44.08	40.00
41.00	SUBPROVIDER - IRF	28	0	28	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	51,361		51,361	324	158.52	43.00
200.00	Total (lines 30 through 199)	517,978		517,978	5,091		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	835	96,960	30.00
31.00	INTENSIVE CARE UNIT	169	66,120	31.00
40.00	SUBPROVIDER - IPF	1,585	69,867	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	2,589	232,947	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/26/2018 10:28 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	268,626	5,904,468	0.045495	252,442	11,485	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,669	22,035,714	0.011648	898,666	10,468	54.00
60.00	06000	LABORATORY	95,506	16,849,765	0.005668	1,071,589	6,074	60.00
65.00	06500	RESPIRATORY THERAPY	42,979	3,243,536	0.013251	571,876	7,578	65.00
66.00	06600	PHYSICAL THERAPY	86,758	1,873,713	0.046303	62,298	2,885	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIAC REHAB	33,243	457,603	0.072646	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,045	2,282,933	0.014475	269,312	3,898	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,612	637,133	0.002530	3,345	8	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,946	9,658,580	0.004550	713,235	3,245	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	109,061	14,505,769	0.007518	645,798	4,855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	57,016	669,396	0.085175	0	0	92.00
93.00	04050	CLINIC	293,063	5,830,412	0.050265	339	17	93.00
93.01	04950	BIC	64	2,108	0.030361	0	0	93.01
93.05	04954	PODIATRY	0	536	0.000000	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,321,588	83,951,666		4,488,900	50,513	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/26/2018 10:28 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
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,254	0.00	835	30.00
31.00	03100	INTENSIVE CARE UNIT		0	271	0.00	169	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,242	0.00	1,585	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	324	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	5,091		2,589	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
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:28 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04050	CLINIC	0	0	0	0	0	93.00
93.01	04950	BIC	0	0	0	0	0	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,904,468	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,035,714	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	16,849,765	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,243,536	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,873,713	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	457,603	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,282,933	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	637,133	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,658,580	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	14,505,769	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	669,396	0.000000	92.00
93.00	04050	CLINIC	0	0	0	5,830,412	0.000000	93.00
93.01	04950	BIC	0	0	0	2,108	0.000000	93.01
93.05	04954	PODIATRY	0	0	0	536	0.000000	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	83,951,666		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:28 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	252,442	0	1,804,092	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	898,666	0	7,591,020	0	54.00
60.00	06000	LABORATORY	0.000000	1,071,589	0	2,809,754	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	571,876	0	1,226,607	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	62,298	0	14,779	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	265,182	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	269,312	0	487,888	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,345	0	218,081	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	713,235	0	2,952,752	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	645,798	0	3,217,316	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	638,795	0	92.00
93.00	04050	CLINIC	0.000000	339	0	1,591,993	0	93.00
93.01	04950	BIC	0.000000	0	0	0	0	93.01
93.05	04954	PODIATRY	0.000000	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,488,900	0	22,818,259	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 10:28 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	0.421743	1,804,092	0	0	760,863	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201676	7,591,020	0	0	1,530,927	54.00
60.00	06000	LABORATORY	0.186643	2,809,754	0	0	524,421	60.00
65.00	06500	RESPIRATORY THERAPY	0.270676	1,226,607	0	0	332,013	65.00
66.00	06600	PHYSICAL THERAPY	0.595193	14,779	0	0	8,796	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.986973	265,182	0	0	261,727	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.490042	487,888	0	0	239,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.563247	218,081	0	0	122,833	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333526	2,952,752	0	28,540	984,820	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.182709	3,217,316	0	0	587,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.921287	638,795	0	0	588,514	92.00
93.00	04050	CLINIC	0.787460	1,591,993	0	0	1,253,631	93.00
93.01	04950	BIC	8.124288	0	0	0	0	93.01
93.05	04954	PODIATRY	0.014925	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		22,818,259	0	28,540	7,195,464	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		22,818,259	0	28,540	7,195,464	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 10:28 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
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
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,519		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04050	CLINIC	0	0		93.00
93.01	04950	BIC	0	0		93.01
93.05	04954	PODIATRY	0	0		93.05
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	9,519		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	9,519		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/26/2018 10:28 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	268,626	5,904,468	0.045495	48	2	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,669	22,035,714	0.011648	151,001	1,759	54.00
60.00	06000	LABORATORY	95,506	16,849,765	0.005668	286,393	1,623	60.00
65.00	06500	RESPIRATORY THERAPY	42,979	3,243,536	0.013251	6,111	81	65.00
66.00	06600	PHYSICAL THERAPY	86,758	1,873,713	0.046303	119,821	5,548	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIAC REHAB	33,243	457,603	0.072646	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,045	2,282,933	0.014475	4,977	72	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,612	637,133	0.002530	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,946	9,658,580	0.004550	491,745	2,237	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	109,061	14,505,769	0.007518	106,481	801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	669,396	0.000000	0	0	92.00
93.00	04050	CLINIC	293,063	5,830,412	0.050265	0	0	93.00
93.01	04950	BIC	64	2,108	0.030361	0	0	93.01
93.05	04954	PODIATRY	0	536	0.000000	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,264,572	83,951,666		1,166,577	12,123	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:28 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04050	CLINIC	0	0	0	0	0	93.00
93.01	04950	BIC	0	0	0	0	0	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,904,468	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,035,714	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	16,849,765	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,243,536	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,873,713	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	457,603	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,282,933	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	637,133	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,658,580	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	14,505,769	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	669,396	0.000000	92.00
93.00	04050	CLINIC	0	0	0	5,830,412	0.000000	93.00
93.01	04950	BIC	0	0	0	2,108	0.000000	93.01
93.05	04954	PODIATRY	0	0	0	536	0.000000	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	83,951,666		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:28 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	48	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	151,001	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	286,393	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,111	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	119,821	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,977	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	491,745	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	106,481	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04050	CLINIC	0.000000	0	0	0	0	93.00
93.01	04950	BIC	0.000000	0	0	0	0	93.01
93.05	04954	PODIATRY	0.000000	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,166,577	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0064 | Component CCN: 15-T064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	268,626	5,904,468	0.045495	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,669	22,035,714	0.011648	0	0	54.00
60.00	06000	LABORATORY	95,506	16,849,765	0.005668	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	42,979	3,243,536	0.013251	0	0	65.00
66.00	06600	PHYSICAL THERAPY	86,758	1,873,713	0.046303	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIAC REHAB	33,243	457,603	0.072646	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,045	2,282,933	0.014475	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,612	637,133	0.002530	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,946	9,658,580	0.004550	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	109,061	14,505,769	0.007518	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	669,396	0.000000	0	0	92.00
93.00	04050	CLINIC	293,063	5,830,412	0.050265	0	0	93.00
93.01	04950	BIC	64	2,108	0.030361	0	0	93.01
93.05	04954	PODIATRY	0	536	0.000000	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,264,572	83,951,666		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0064
Component CCN: 15-T064

Period:
From 10/01/2016
To 09/30/2017

Worksheet D
Part IV
Date/Time Prepared:
2/26/2018 10:28 am

Title XVIII

Subprovider - IRF

PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04050	CLINIC	0	0	0	0	0	93.00
93.01	04950	BIC	0	0	0	0	0	93.01
93.05	04954	PODIATRY	0	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0064 | Component CCN: 15-T064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,904,468	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,035,714	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	16,849,765	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,243,536	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,873,713	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	457,603	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,282,933	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	637,133	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,658,580	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	14,505,769	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	669,396	0.000000	92.00
93.00	04050	CLINIC	0	0	0	5,830,412	0.000000	93.00
93.01	04950	BIC	0	0	0	2,108	0.000000	93.01
93.05	04954	PODIATRY	0	0	0	536	0.000000	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	83,951,666		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0064 | Component CCN: 15-T064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04050	CLINIC	0.000000	0	0	0	0	93.00
93.01	04950	BIC	0.000000	0	0	0	0	93.01
93.05	04954	PODIATRY	0.000000	0	0	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 10:28 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)	2,254	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,254	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)	1,763	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)	835	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)	2,831,075	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)	2,831,075	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)	2,831,075	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)	1,256.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,048,777	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)	1,048,777	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,543,787	271	5,696.63	169	962,730	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)	1,169,591	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,181,098	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)	163,080	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	50,513	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	213,593	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,967,505	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)	491	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,256.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	616,706	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 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	261,740	2,831,075	0.092453	616,706	57,016	90.00
91.00	Nursing School cost	0	2,831,075	0.000000	616,706	0	91.00
92.00	Allied health cost	0	2,831,075	0.000000	616,706	0	92.00
93.00	All other Medical Education	0	2,831,075	0.000000	616,706	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064 Component CCN: 15-S064	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 10:28 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)	2,242	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,242	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)	2,242	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)	1,585	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)	2,608,660	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)	2,608,660	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)	2,608,660	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)	1,163.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,844,211	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)	1,844,211	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	342,801	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,187,012	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)	69,867	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,123	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	81,990	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,105,022	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: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 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	98,822	2,608,660	0.037882	0	0	90.00
91.00	Nursing School cost	0	2,608,660	0.000000	0	0	91.00
92.00	Allied health cost	0	2,608,660	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,608,660	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064 Component CCN: 15-T064	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 10:28 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	0	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)	0	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,485	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,485	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,485	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)	0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0064 | Component CCN: 15-T064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Subprovider - IRF | PPS

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

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0064 | Component CCN: 15-T064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	28	7,485	0.003741	0	0	90.00
91.00	Nursing School cost	0	7,485	0.000000	0	0	91.00
92.00	Allied health cost	0	7,485	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,485	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 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)	2,254	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,254	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)	1,763	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)	68	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)	324	15.00
16.00	Nursery days (title V or XIX only)	24	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)	2,831,075	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)	2,831,075	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)	2,831,075	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)	1,256.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	85,409	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)	85,409	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 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)	704,501	324	2,174.39	24	52,185	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,543,787	271	5,696.63	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)	142,076	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	279,670	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)	491	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,256.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	616,706	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 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	261,740	2,831,075	0.092453	616,706	57,016	90.00
91.00	Nursing School cost	0	2,831,075	0.000000	616,706	0	91.00
92.00	Allied health cost	0	2,831,075	0.000000	616,706	0	92.00
93.00	All other Medical Education	0	2,831,075	0.000000	616,706	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064 Component CCN: 15-S064	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 10:28 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,242	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,242	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)	2,242	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)	195	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)	324	15.00
16.00	Nursery days (title V or XIX only)	24	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)	2,608,660	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)	2,608,660	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)	2,608,660	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)	1,163.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	226,890	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)	226,890	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 am

Title XIX | Subprovider - IPF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	70,357	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	297,247	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:28 am

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	98,822	2,608,660	0.037882	0	0	90.00
91.00	Nursing School cost	0	2,608,660	0.000000	0	0	91.00
92.00	Allied health cost	0	2,608,660	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,608,660	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 10:28 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		1,233,649		30.00
31.00	03100	INTENSIVE CARE UNIT		488,711		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.421743	252,442	106,466	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201676	898,666	181,239	54.00
60.00	06000	LABORATORY	0.186643	1,071,589	200,005	60.00
65.00	06500	RESPIRATORY THERAPY	0.270676	571,876	154,793	65.00
66.00	06600	PHYSICAL THERAPY	0.595193	62,298	37,079	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHAB	0.986973	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.490042	269,312	131,974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.563247	3,345	1,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333526	713,235	237,882	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.182709	645,798	117,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.921287	0	0	92.00
93.00	04050	CLINIC	0.813441	339	276	93.00
93.01	04950	BIC	8.124288	0	0	93.01
93.05	04954	PODIATRY	0.014925	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,488,900	1,169,591	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)		4,488,900		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 10:28 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		2,739,511		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.421743	48	20	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201676	151,001	30,453	54.00
60.00	06000	LABORATORY	0.186643	286,393	53,453	60.00
65.00	06500	RESPIRATORY THERAPY	0.270676	6,111	1,654	65.00
66.00	06600	PHYSICAL THERAPY	0.595193	119,821	71,317	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHAB	0.986973	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.490042	4,977	2,439	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.563247	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333526	491,745	164,010	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.182709	106,481	19,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.921287	0	0	92.00
93.00	04050	CLINIC	0.813441	0	0	93.00
93.01	04950	BIC	8.124288	0	0	93.01
93.05	04954	PODIATRY	0.014925	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,166,577	342,801	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)		1,166,577		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 10:28 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		47,316		30.00
31.00	03100	INTENSIVE CARE UNIT		7,547		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		15,716		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.421743	46,857	19,762	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201676	19,050	3,842	54.00
60.00	06000	LABORATORY	0.186643	225,465	42,081	60.00
65.00	06500	RESPIRATORY THERAPY	0.270676	25,700	6,956	65.00
66.00	06600	PHYSICAL THERAPY	0.595193	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHAB	0.986973	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.490042	46,737	22,903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.563247	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333526	102,602	34,220	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.182709	67,387	12,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.921287	0	0	92.00
93.00	04050	CLINIC	0.787460	0	0	93.00
93.01	04950	BIC	8.124288	0	0	93.01
93.05	04954	PODIATRY	0.014925	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		533,798	142,076	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)		533,798		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 10:28 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		42,241		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.421743	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201676	31,888	6,431	54.00
60.00	06000	LABORATORY	0.186643	56,314	10,511	60.00
65.00	06500	RESPIRATORY THERAPY	0.270676	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.595193	24,035	14,305	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHAB	0.986973	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.490042	956	468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.563247	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333526	100,974	33,677	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.182709	27,176	4,965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.921287	0	0	92.00
93.00	04050	CLINIC	0.787460	0	0	93.00
93.01	04950	BIC	8.124288	0	0	93.01
93.05	04954	PODIATRY	0.014925	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		241,343	70,357	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)		241,343		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0064 | Component CCN: 15-U064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 10:28 am

Title XIX | Swing Beds - SNF | 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		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.421743	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201676	0	0	54.00
60.00	06000	LABORATORY	0.186643	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.270676	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.595193	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHAB	0.986973	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.490042	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.563247	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.333526	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.182709	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.921287	0	0	92.00
93.00	04050	CLINIC	0.787460	0	0	93.00
93.01	04950	BIC	8.124288	0	0	93.01
93.05	04954	PODIATRY	0.014925	0	0	93.05
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 10:28 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)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,630,424	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)	25,767	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)	43.65	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 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)	5.27	30.00
31.00	Percentage of Medicaid patient days (see instructions)	37.35	31.00
32.00	Sum of lines 30 and 31	42.62	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	48,913	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 10:28 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000040126	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	239,852	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	239,852	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	239,852		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
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	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	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)	1,944,956		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)		1,944,956	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		131,478	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		0	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)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		2,076,434	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		2,076,434	61.00
62.00	Deductibles billed to program beneficiaries		295,652	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		40,831	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		26,540	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		17,065	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,807,322	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		12,775	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 10:28 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2017	385,253	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)		2,205,350	71.00
71.01	Sequestration adjustment (see instructions)		44,107	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		1,993,097	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)		168,146	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		273,700	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
	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 (line 209 plus line 210) (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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,630,424	0		1,630,424	1,630,424	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	25,767	0	0	25,767	25,767	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	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	48,913	0	0	48,913	48,913	11.00
11.01	Uncompensated care payments	36.00	239,852	0	0	239,852	239,852	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	1,944,956	0	0	1,944,956	1,944,956	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	1,944,956	0	0	1,944,956	1,944,956	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	131,478	0	0	131,478	131,478	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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	2,076,434	2,076,434	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	129,530	0	0	129,530	129,530	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,948	0	0	1,948	1,948	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	131,478	0	0	131,478	131,478	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.185536		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				385,253	385,253	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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,630,424		1,630,424	1,630,424	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	25,767	0	25,767	25,767	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	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	48,913	0	48,913	48,913	11.00
11.01	Uncompensated care payments	36.00	239,852	0	239,852	239,852	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	1,944,956	0	1,944,956	1,944,956	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	1,944,956	0	1,944,956	1,944,956	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	131,478	0	131,478	131,478	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			0	2,076,434	2,076,434	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2018 10:28 am
	Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	129,530	0	129,530	129,530	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,948	0	1,948	1,948	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	131,478	0	131,478	131,478	26.00

		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	385,253		385,253	385,253	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	12,775	0	12,775	12,775	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	0	0	0	0	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: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/26/2018 10:28 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,519	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,195,464	2.00
3.00	OPPS payments	4,750,042	3.00
4.00	Outlier payment (see instructions)	11,097	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,519	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	28,540	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)	28,540	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)	28,540	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	19,021	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (see instructions)	9,519	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)	4,761,139	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	996,533	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)	3,774,125	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)	3,774,125	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,774,125	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)	181,894	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	118,231	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	164,148	36.00
37.00	Subtotal (see instructions)	3,892,356	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	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)	3,892,356	40.00
40.01	Sequestration adjustment (see instructions)	77,847	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,829,219	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-14,710	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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 10:28 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		1,993,097		3,698,269	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	09/30/2017	130,950	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		130,950	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)		1,993,097		3,829,219	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		168,146		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		14,710	6.02
7.00	Total Medicare program liability (see instructions)		2,161,243		3,814,509	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: 15-0064 | Component CCN: 15-S064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 10:28 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		1,384,932		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)		1,384,932		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		23,758		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,408,690		0	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: 15-0064 | Component CCN: 15-U064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		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)		0		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/26/2018 10:28 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 - SWING BEDS

Provider CCN: 15-0064 | Component CCN: 15-U064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-2 | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-0064 Component CCN: 15-U064	Period: From 10/01/2016 To 09/30/2017	Worksheet E-2 Date/Time Prepared: 2/26/2018 10:28 am
	Title XIX	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064 Component CCN: 15-S064	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part II Date/Time Prepared: 2/26/2018 10:28 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,522,338	1.00
2.00	Net IPF PPS Outlier Payments	30,979	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)	6.142466	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,553,317	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,553,317	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,553,317	18.00
19.00	Deductibles	100,912	19.00
20.00	Subtotal (line 18 minus line 19)	1,452,405	20.00
21.00	Coinsurance	39,207	21.00
22.00	Subtotal (line 20 minus line 21)	1,413,198	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,294	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	24,241	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,572	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,437,439	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)	0	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)	1,437,439	31.00
31.01	Sequestration adjustment (see instructions)	28,749	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,384,932	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)	23,758	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	30,979	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: 15-0064 Component CCN: 15-T064	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part III Date/Time Prepared: 2/26/2018 10:28 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	0	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	0	3.00
4.00	Outlier Payments	0	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	0.000000	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	0	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	0	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	0	19.00
20.00	Deductibles	0	20.00
21.00	Subtotal (line 19 minus line 20)	0	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	0	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	0	32.00
32.01	Sequestration adjustment (see instructions)	0	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	0	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	0	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	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: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 2/26/2018 10:28 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	279,670		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)	279,670	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)	279,670	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	96,990		8.00
9.00	Ancillary service charges	533,798	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)	630,788	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)	630,788	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	351,118	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)	279,670	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)	279,670	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)	279,670	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)	279,670	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	279,670	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)	279,670	0	40.00
41.00	Interim payments	355,467	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-75,797	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064 Component CCN: 15-S064	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 2/26/2018 10:28 am
	Title XIX	Subprovider - IPF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	297,247		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)	297,247	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)	297,247	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	42,241		8.00
9.00	Ancillary service charges	241,343	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)	283,584	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)	283,584	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	13,663	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)	283,584	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)	283,584	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	13,663	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	283,584	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)	283,584	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	283,584	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)	283,584	0	40.00
41.00	Interim payments	160,611	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	122,973	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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/26/2018 10:28 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	2,651,513	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	5,173,248	0	0	0	4.00
5.00	Other receivable	1,422,150	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	785,209	0	0	0	7.00
8.00	Prepaid expenses	369,636	0	0	0	8.00
9.00	Other current assets	0	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)	10,401,756	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,003,725	0	0	0	12.00
13.00	Land improvements	471,366	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	51,320,484	0	0	0	15.00
16.00	Accumulated depreciation	-57,027,025	0	0	0	16.00
17.00	Leasehold improvements	1,143,979	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	22,981,870	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)	19,894,399	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,197,406	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	2,469,367	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,666,773	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,962,928	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,319,206	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,234,013	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,133,422	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	461,597	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,148,238	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	15,213,045	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)	15,213,045	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,361,283	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,601,645				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)	13,601,645	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,962,928	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/26/2018 10:28 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		13,803,321		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-201,676				2.00
3.00	Total (sum of line 1 and line 2)		13,601,645		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)		13,601,645		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)		13,601,645		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: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/26/2018 10:28 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,008,160		4,008,160	1.00
2.00	SUBPROVIDER - IPF	4,552,489		4,552,489	2.00
3.00	SUBPROVIDER - IRF	1,087		1,087	3.00
4.00	SUBPROVIDER	0		0	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)	8,561,736		8,561,736	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,490,477		1,490,477	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)	1,490,477		1,490,477	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,052,213		10,052,213	17.00
18.00	Ancillary services	8,060,422	54,890,610	62,951,032	18.00
19.00	Outpatient services	899,503	25,065,139	25,964,642	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		19,071	19,071	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	18,528	18,528	26.00
27.00	OTHER NONREIMBURSABLE COST CENTERS	6,415,812	727,559	7,143,371	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	25,427,950	80,720,907	106,148,857	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		49,376,826		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)		49,376,826		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0064 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/26/2018 10:28 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	106,148,857	1.00
2.00	Less contractual allowances and discounts on patients' accounts	64,349,406	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,799,451	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	49,376,826	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,577,375	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	6,305,087	24.00
24.01	INVESTMEENT RETURN	1,101,705	24.01
24.02	OTHER NON-OPERATING REVENUE	-2,035	24.02
25.00	Total other income (sum of lines 6-24)	7,404,757	25.00
26.00	Total (line 5 plus line 25)	-172,618	26.00
27.00	CHANGE IN NET ASSETS OF FOUNDATION	29,058	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	29,058	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-201,676	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0064 HHA CCN: 15-7097 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H Date/Time Prepared: 2/26/2018 10:28 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	7,747	0	0	0	14,932	22,679	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	6,505	0	0	0	0	6,505	6.00
7.00	Physical Therapy	3,487	0	0	0	0	3,487	7.00
8.00	Occupational Therapy	2,783	0	0	0	0	2,783	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	1,375	0	0	0	0	1,375	10.00
11.00	Home Health Aide	2,254	0	0	0	0	2,254	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	24,151	0	0	0	14,932	39,083	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	274	22,953	0	22,953			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	6,505	0	6,505			6.00
7.00	Physical Therapy	0	3,487	0	3,487			7.00
8.00	Occupational Therapy	0	2,783	0	2,783			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	1,375	0	1,375			10.00
11.00	Home Health Aide	0	2,254	0	2,254			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	274	39,357	0	39,357			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-0064 HHA CCN: 15-7097

Period: From 10/01/2016 To 09/30/2017

Worksheet H-1 Part I Date/Time Prepared: 2/26/2018 10:28 am

Home Health Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	22,953	0	0	0	0	22,953	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	6,505	0	0	0	0	6,505	6.00
7.00	Physical Therapy	3,487	0	0	0	0	3,487	7.00
8.00	Occupational Therapy	2,783	0	0	0	0	2,783	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	1,375	0	0	0	0	1,375	10.00
11.00	Home Health Aide	2,254	0	0	0	0	2,254	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	39,357	0	0	0	0	39,357	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	22,953		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	9,102	15,607	6.00
7.00	Physical Therapy	4,879	8,366	7.00
8.00	Occupational Therapy	3,894	6,677	8.00
9.00	Speech Pathology	0	0	9.00
10.00	Medical Social Services	1,924	3,299	10.00
11.00	Home Health Aide	3,154	5,408	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		39,357	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0064 HHA CCN: 15-7097 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part II Date/Time Prepared: 2/26/2018 10:28 am

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-22,953	16,404	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6,505	6.00
7.00	Physical Therapy	0	0	0	0	0	3,487	7.00
8.00	Occupational Therapy	0	0	0	0	0	2,783	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	1,375	10.00
11.00	Home Health Aide	0	0	0	0	0	2,254	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-22,953	16,404	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		22,953	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		1.399232	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0064 HHA CCN: 15-7097

Period: From 10/01/2016 To 09/30/2017

Worksheet H-2 Part I Date/Time Prepared: 2/26/2018 10:28 am

Home Health Agency I

PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	0	5,998	5,998	1,169	0	1.00
2.00	Skilled Nursing Care	15,607	0	0	15,607	3,043	0	2.00
3.00	Physical Therapy	8,366	0	0	8,366	1,631	0	3.00
4.00	Occupational Therapy	6,677	0	0	6,677	1,302	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	3,299	0	0	3,299	643	0	6.00
7.00	Home Health Aide	5,408	0	0	5,408	1,054	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	39,357	0	5,998	45,355	8,842	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	2,556	10,130	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	2,556	10,130	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0064 HHA CCN: 15-7097 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part I Date/Time Prepared: 2/26/2018 10:28 am

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	300	20,153	0	20,153	1.00
2.00	Skilled Nursing Care	0	0	0	18,650	0	18,650	2.00
3.00	Physical Therapy	0	0	0	9,997	0	9,997	3.00
4.00	Occupational Therapy	0	0	0	7,979	0	7,979	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	3,942	0	3,942	6.00
7.00	Home Health Aide	0	0	0	6,462	0	6,462	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	300	67,183	0	67,183	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	7,992	26,642					2.00
3.00	Physical Therapy	4,284	14,281					3.00
4.00	Occupational Therapy	3,419	11,398					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	1,689	5,631					6.00
7.00	Home Health Aide	2,769	9,231					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	20,153	67,183					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.428514						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0064 HHA CCN: 15-7097 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part II Date/Time Prepared: 2/26/2018 10:28 am

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	7.01	
1.00	Administrative and General	0	24,425	0	5,998	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	15,607	0	0	2.00
3.00	Physical Therapy	0	0	0	8,366	0	0	3.00
4.00	Occupational Therapy	0	0	0	6,677	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	3,299	0	0	6.00
7.00	Home Health Aide	0	0	0	5,408	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	24,425		45,355	0	0	20.00
21.00	Total cost to be allocated	0	5,998		8,842	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.245568		0.194951	0.000000	0.000000	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	2,079	100	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	2,079	100	0	20.00
21.00	Total cost to be allocated	0	0	0	2,556	10,130	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	1.229437	101.300000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0064 HHA CCN: 15-7097 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part II Date/Time Prepared: 2/26/2018 10:28 am

Home Health Agency I | PPS

	Cost Center Description	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)			
		15.00	16.00			
1.00	Administrative and General	0	19,071			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	0	19,071			20.00
21.00	Total cost to be allocated	0	300			21.00
22.00	Unit cost multiplier	0.000000	0.015731			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0064 | HHA CCN: 15-7097 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	26,642		26,642	223	119.47	1.00
2.00	Physical Therapy	3.00	14,281	0	14,281	19	751.63	2.00
3.00	Occupational Therapy	4.00	11,398	0	11,398	22	518.09	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	5,631		5,631	0	0.00	5.00
6.00	Home Health Aide	7.00	9,231		9,231	126	73.26	6.00
7.00	Total (sum of lines 1-6)		67,183	0	67,183	390		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		17140	0	9			8.00
8.01	Skilled Nursing Care		99915	0	42			8.01
9.00	Physical Therapy		17140	0	0			9.00
9.01	Physical Therapy		99915	0	14			9.01
10.00	Occupational Therapy		17140	0	14			10.00
10.01	Occupational Therapy		99915	0	8			10.01
11.00	Speech Pathology		17140	0	0			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		17140	0	0			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		17140	0	17			13.00
13.01	Home Health Aide		99915	0	39			13.01
14.00	Total (sum of lines 8-13)			0	143			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	51		0	6,093		1.00
2.00	Physical Therapy	0	14		0	10,523		2.00
3.00	Occupational Therapy	0	22		0	11,398		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	56		0	4,103		6.00
7.00	Total (sum of lines 1-6)	0	143		0	32,117		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0064 HHA CCN: 15-7097 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	6,093		1.00
2.00	Physical Therapy	10,523		2.00
3.00	Occupational Therapy	11,398		3.00
4.00	Speech Pathology	0		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	4,103		6.00
7.00	Total (sum of lines 1-6)	32,117		7.00

	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0064 HHA CCN: 15-7097 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part II Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.595193	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.490042	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.333526	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0064 | HHA CCN: 15-7097 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/26/2018 10:28 am

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	15,995	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	15,995	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	15,995	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	11,174	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	120	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,712	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	15,006	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	15,006	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	15,006	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	15,006	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	15,006	31.00
31.01	Sequestration adjustment (see instructions)	0	300	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	14,706	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0064 HHA CCN: 15-7097

Period: From 10/01/2016 To 09/30/2017

Worksheet H-5

Date/Time Prepared: 2/26/2018 10:28 am

Home Health Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		14,706	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		14,706	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		14,706	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0064
Hospice CCN: 15-1548

Period: From 10/01/2016 To 09/30/2017

Worksheet O
Date/Time Prepared: 2/26/2018 10:28 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*	0	0	0	0	0	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	0	0	0	121	121	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	43	43	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	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	4,847	4,847	0	4,847	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	0	4,847	4,847	164	5,011	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: 15-0064 | Hospice CCN: 15-1548 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O | Date/Time Prepared: 2/26/2018 10:28 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*	0	0		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	121		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	43		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	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	4,847		42.00
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	5,011		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: 15-0064 Hospice CCN: 15-1548

Period: From 10/01/2016 To 09/30/2017

Worksheet O-2 Date/Time Prepared: 2/26/2018 10:28 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	121	121	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	43	43	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	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	4,847	4,847	0	4,847	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	4,847	4,847	164	5,011	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	121		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	43		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	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	4,847		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	5,011		100.00

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

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

Provider CCN: 15-0064 Hospice CCN: 15-1548

Period: From 10/01/2016 To 09/30/2017

Worksheet O-5

Date/Time Prepared: 2/26/2018 10:28 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	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	40	40	3.00
4.00	ADMINISTRATIVE & GENERAL	0	985	985	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	291	291	11.00
12.00	STAFF TRANSPORTATION	0		0	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	5,011		5,011	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	5,011	1,316	6,327	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0064
Hospice CCN: 15-1548

Period: From 10/01/2016 To 09/30/2017

Worksheet O-6 Part I
Date/Time Prepared: 2/26/2018 10:28 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	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	40	0	0	40		3.00
4.00	ADMINISTRATIVE & GENERAL	985	0	0	0	985	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	291	0	0	0	291	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		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	5,011			40	5,051	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	6,327	0	0	40	6,327	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0064
Hospice CCN: 15-1548

Period: From 10/01/2016 To 09/30/2017

Worksheet O-6 Part I
Date/Time Prepared: 2/26/2018 10:28 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	985					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	54	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	931					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	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	985	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0064
Hospice CCN: 15-1548

Period: From 10/01/2016 To 09/30/2017

Worksheet O-6 Part I
Date/Time Prepared: 2/26/2018 10:28 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	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		345			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	345	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	345	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0064
Hospice CCN: 15-1548

Period: From 10/01/2016 To 09/30/2017

Worksheet O-6 Part I
Date/Time Prepared: 2/26/2018 10:28 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		6,327	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	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	6,327	100.00

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

Provider CCN: 15-0064
Hospice CCN: 15-1548

Period:
From 10/01/2016
To 09/30/2017

Worksheet O-6
Part II
Date/Time Prepared:
2/26/2018 10:28 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	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-985	5,342	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	291	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	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			1	0	5,051	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	40		985	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	40.000000		0.184388	101.00

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

Provider CCN: 15-0064
Hospice CCN: 15-1548

Period:
From 10/01/2016
To 09/30/2017

Worksheet O-6
Part II
Date/Time Prepared:
2/26/2018 10:28 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	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	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)	0	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-0064
Hospice CCN: 15-1548

Period:
From 10/01/2016
To 09/30/2017

Worksheet O-6
Part II
Date/Time Prepared:
2/26/2018 10:28 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	0					10.00
11.00	MEDICAL RECORDS		36				11.00
12.00	STAFF TRANSPORTATION			0			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	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	0	36	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	345	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	9.583333	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-0064
Hospice CCN: 15-1548

Period:
From 10/01/2016
To 09/30/2017

Worksheet O-6
Part II
Date/Time Prepared:
2/26/2018 10:28 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: 15-0064 Hospice CCN: 15-1548

Period: From 10/01/2016 To 09/30/2017

Worksheet O-7

Date/Time Prepared: 2/26/2018 10:28 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	0.595193	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.333526	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.186643	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.490042	0	0	0	7.00
8.00	CLINIC	93.00	0.787460	0	0	0	8.00
8.01	BIC	93.01	8.124288	0	0	0	8.01
8.05	PODIATRY	93.05	0.014925	0	0	0	8.05
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						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	CLINIC	0	0	0	0	0	8.00
8.01	BIC	0	0	0	0	0	8.01
8.05	PODIATRY	0	0	0	0	0	8.05
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0064 Hospice CCN: 15-1548

Period: From 10/01/2016 To 09/30/2017

Worksheet O-8

Date/Time Prepared: 2/26/2018 10:28 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)			6,327	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			36	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			175.75	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	0	0		9.00
10.00	Program cost (line 8 times line 9)	0	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)			0	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
	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)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			6,327	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			36	22.00
23.00	Average cost per diem (line 21 divided by line 22)			175.75	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet L Parts I-III Date/Time Prepared: 2/26/2018 10:28 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	129,530	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,948	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)	5.68	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)	131,478	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