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: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet S Parts I-III Date/Time Prepared: 9/12/2017 9:05 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/12/2017 Time: 9:05 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROCHELLE COMMUNITY HOSPITAL (14-1312) for the cost reporting period beginning 05/01/2016 and ending 04/30/2017 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.

(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	-104,717	-376,984	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	26,488	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-78,229	-376,984	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 9/12/2017 9:02 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 900 NORTH 2ND STREET	PO Box:			1.00
2.00	City: ROCHELLE	State: IL	Zip Code: 61068	County: OGLE	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	ROCHELLE COMMUNITY HOSPITAL	141312	99914	1	05/01/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ROCHELLE COMMUNITY HOSPITAL	14Z312	99914		04/17/1987	N	N	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2016	04/30/2017	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.	N	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.	1	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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 9/12/2017 9:02 am

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 9/12/2017 9:02 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 9/12/2017 9:02 am

		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.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 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)			0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		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.	Y	Y	N	Y	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	328,644	54,416	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/12/2017 9:02 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

		1.00	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.	Y		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)	1	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/12/2017 9:02 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 9/12/2017 9:02 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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	06/01/2017	Y	06/01/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 9/12/2017 9:02 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.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4389		KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part II Date/Time Prepared: 9/12/2017 9:02 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.	DIRECTOR		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: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 9/12/2017 9:02 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	12	4,380	34,184.00	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)		12	4,380	34,184.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		16	5,840	34,184.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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)		16				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 9/12/2017 9:02 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)	798	137	1,334			1.00
2.00	HMO and other (see instructions)	166	0				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	98	0	98			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)	896	137	1,432			7.00
8.00	INTENSIVE CARE UNIT	7	0	8			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)	903	137	1,440	0.00	292.70	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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	292.70	27.00
28.00	Observation Bed Days		0	431			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	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 9/12/2017 9:02 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	274	59	492	1.00
2.00	HMO and other (see instructions)			52	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	274	59	492	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-10 | Date/Time Prepared: 9/12/2017 9:02 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)	0.406147	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,626,487	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	10,170,962	6.00
7.00	Medicaid cost (line 1 times line 6)	4,130,906	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)	1,504,419	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	24,877	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,504,419	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	1,183,278	20,841	1,204,119	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	480,585	8,465	489,050	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	480,585	8,465	489,050	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,056,197	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	398,342	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,657,855	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	673,333	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,162,383	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,666,802	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A | Date/Time Prepared: 9/12/2017 9:02 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		1,013,161	1,013,161	514,498	1,527,659	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,318,823	1,318,823	-192,707	1,126,116	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	174,887	4,319,316	4,494,203	0	4,494,203	4.00
5.01	00570	ADMITTING	363,612	18,596	382,208	103,386	485,594	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	490,629	275,162	765,791	0	765,791	5.02
5.03	00590	OTHER ADMIN & GENERAL	1,427,253	2,215,331	3,642,584	29,149	3,671,733	5.03
7.00	00700	OPERATION OF PLANT	377,625	968,531	1,346,156	0	1,346,156	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	89,087	89,087	8.00
9.00	00900	HOUSEKEEPING	347,805	113,079	460,884	-66,794	394,090	9.00
10.00	01000	DIETARY	292,763	186,511	479,274	-328,734	150,540	10.00
11.00	01100	CAFETERIA	0	0	0	328,734	328,734	11.00
13.00	01300	NURSING ADMINISTRATION	175,099	93,232	268,331	0	268,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	131,059	43,641	174,700	-22,293	152,407	14.00
15.00	01500	PHARMACY	185,537	1,233,472	1,419,009	0	1,419,009	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	474,940	121,082	596,022	0	596,022	16.00
17.00	01700	SOCIAL SERVICE	215,312	23,730	239,042	0	239,042	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,669,945	160,255	1,830,200	0	1,830,200	30.00
31.00	03100	INTENSIVE CARE UNIT	4,638	12,461	17,099	0	17,099	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	879,534	719,760	1,599,294	0	1,599,294	50.00
53.00	05300	ANESTHESIOLOGY	0	283,132	283,132	0	283,132	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	664,792	1,518,406	2,183,198	0	2,183,198	54.00
60.00	06000	LABORATORY	713,826	857,070	1,570,896	-8,833	1,562,063	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	76,574	76,574	10,427	87,001	62.00
64.00	06400	INTRAVENOUS THERAPY	221,427	15,409	236,836	0	236,836	64.00
65.00	06500	RESPIRATORY THERAPY	11,750	1,024,561	1,036,311	-16,946	1,019,365	65.00
66.00	06600	PHYSICAL THERAPY	0	815,518	815,518	-76,869	738,649	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	76,869	76,869	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,977	12,977	0	12,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	206,939	206,939	0	206,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	38,132	2,437	40,569	0	40,569	90.01
91.00	09100	EMERGENCY	1,512,545	1,058,078	2,570,623	-1,594	2,569,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		257,004	257,004	-257,004	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,373,110	18,964,248	29,337,358	180,376	29,517,734	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	299,402	143,714	443,116	0	443,116	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	170,023	4,525	174,548	-174,548	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	1,717,279	360,659	2,077,938	-5,828	2,072,110	194.03
194.04	07954	340B PHARMACY	0	11,420	11,420	0	11,420	194.04
200.00		TOTAL (SUM OF LINES 118-199)	12,559,814	19,484,566	32,044,380	0	32,044,380	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A | Date/Time Prepared: 9/12/2017 9:02 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	-96,269	1,431,390		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-124,335	1,001,781		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-27,574	4,466,629		4.00
5.01	00570	ADMITTING	0	485,594		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	765,791		5.02
5.03	00590	OTHER ADMIN & GENERAL	-931,780	2,739,953		5.03
7.00	00700	OPERATION OF PLANT	-700	1,345,456		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	89,087		8.00
9.00	00900	HOUSEKEEPING	0	394,090		9.00
10.00	01000	DIETARY	0	150,540		10.00
11.00	01100	CAFETERIA	-142,612	186,122		11.00
13.00	01300	NURSING ADMINISTRATION	-1,730	266,601		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-13,350	139,057		14.00
15.00	01500	PHARMACY	0	1,419,009		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,776	589,246		16.00
17.00	01700	SOCIAL SERVICE	0	239,042		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,830,200		30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,099		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-31,750	1,567,544		50.00
53.00	05300	ANESTHESIOLOGY	-282,440	692		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-12,726	2,170,472		54.00
60.00	06000	LABORATORY	0	1,562,063		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	87,001		62.00
64.00	06400	INTRAVENOUS THERAPY	-1,000	235,836		64.00
65.00	06500	RESPIRATORY THERAPY	-116,400	902,965		65.00
66.00	06600	PHYSICAL THERAPY	-61,622	677,027		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	76,869		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,977		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	206,939		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	DIABETIC SERVICES	0	40,569		90.01
91.00	09100	EMERGENCY	-879,472	1,689,557		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,730,536	26,787,198		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	443,116		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	0		194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,072,110		194.03
194.04	07954	340B PHARMACY	0	11,420		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-2,730,536	29,313,844		200.00

RECLASSIFICATIONS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-6 | Date/Time Prepared: 9/12/2017 9:02 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	64,787		1.00
	0		0	64,787		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	200,806	127,928		1.00
	0		200,806	127,928		
	C - RECEPTIONIST-NURSING					
1.00	ADMITTING	5.01	100,706	2,680		1.00
2.00	RESPIRATORY THERAPY	65.00	69,317	1,845		2.00
	0		170,023	4,525		
	E - FITNESS CENTER					
1.00	OTHER ADMIN & GENERAL	5.03	0	88,108		1.00
	0		0	88,108		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	257,004		1.00
	0		0	257,004		
	G - EKG'S					
1.00	LABORATORY	60.00	1,594	0		1.00
	0		1,594	0		
	H - FIXED EQUIPMENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	213,008		1.00
	0		0	213,008		
	I - THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	0	76,869		1.00
	0		0	76,869		
	J - LAUNDRY AND LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	89,087		1.00
2.00		0.00	0	0		2.00
	0		0	89,087		
	L - PHYSICIAN ADMIN COSTS					
1.00	OTHER ADMIN & GENERAL	5.03	5,828	0		1.00
	TOTALS		5,828	0		
	M - BLOOD BANK SALARIES					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	10,427	0		1.00
	TOTALS		10,427	0		
500.00	Grand Total: Increases		388,678	921,316		500.00

RECLASSIFICATIONS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-6 | Date/Time Prepared: 9/12/2017 9:02 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.03	0	64,787	12		1.00
	0		0	64,787			
	B - CAFETERIA						
1.00	DIETARY	10.00	200,806	127,928	0		1.00
	0		200,806	127,928			
	C - RECEPTIONIST-NURSING						
1.00	PHYSICIANS CLINICS	194.02	170,023	4,525	0		1.00
2.00		0.00	0	0	0		2.00
	0		170,023	4,525			
	E - FITNESS CENTER						
1.00	RESPIRATORY THERAPY	65.00	0	88,108	0		1.00
	0		0	88,108			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	257,004	11		1.00
	0		0	257,004			
	G - EKG'S						
1.00	EMERGENCY	91.00	1,594	0	0		1.00
	0		1,594	0			
	H - FIXED EQUIPMENT						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	213,008	9		1.00
	0		0	213,008			
	I - THERAPY						
1.00	PHYSICAL THERAPY	66.00	0	76,869	0		1.00
	0		0	76,869			
	J - LAUNDRY AND LINEN						
1.00	HOUSEKEEPING	9.00	0	66,794	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	22,293	0		2.00
	0		0	89,087			
	L - PHYSICIAN ADMIN COSTS						
1.00	HEALTH & WELLNESS CENTER	194.03	5,828	0	0		1.00
	TOTALS		5,828	0			
	M - BLOOD BANK SALARIES						
1.00	LABORATORY	60.00	10,427	0	0		1.00
	TOTALS		10,427	0			
500.00	Grand Total: Decreases		388,678	921,316			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 9/12/2017 9:02 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	3,389,097	0	0	0	0	1.00
2.00	Land Improvements	1,154,439	295,064	0	295,064	0	2.00
3.00	Buildings and Fixtures	12,459,518	7,757,234	0	7,757,234	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,817,555	760,665	0	760,665	0	5.00
6.00	Movable Equipment	8,727,196	588,899	0	588,899	696,972	6.00
7.00	HIT designated Assets	4,096,865	0	0	0	105,842	7.00
8.00	Subtotal (sum of lines 1-7)	31,644,670	9,401,862	0	9,401,862	802,814	8.00
9.00	Reconciling Items	-8,219,540	0	0	0	-7,889,547	9.00
10.00	Total (line 8 minus line 9)	39,864,210	9,401,862	0	9,401,862	8,692,361	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,389,097	0	1.00
2.00	Land Improvements	1,449,503	0	2.00
3.00	Buildings and Fixtures	20,216,752	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,578,220	0	5.00
6.00	Movable Equipment	8,619,123	0	6.00
7.00	HIT designated Assets	3,991,023	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,243,718	0	8.00
9.00	Reconciling Items	-329,993	0	9.00
10.00	Total (line 8 minus line 9)	40,573,711	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part II Date/Time Prepared: 9/12/2017 9:02 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	996,060	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,318,823	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,314,883	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	17,101	1,013,161		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,318,823		2.00
3.00	Total (sum of lines 1-2)	17,101	2,331,984		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 9/12/2017 9:02 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	27,633,572	0	27,633,572	0.686656	44,486	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,610,146	0	12,610,146	0.313344	20,301	2.00
3.00	Total (sum of lines 1-2)	40,243,718	0	40,243,718	1.000000	64,787	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	44,486	1,209,068	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	20,301	981,480	0	2.00
3.00	Total (sum of lines 1-2)	0	0	64,787	2,190,548	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	160,735	44,486	0	17,101	1,431,390	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,301	0	0	1,001,781	2.00
3.00	Total (sum of lines 1-2)	160,735	64,787	0	17,101	2,433,171	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8 | Date/Time Prepared: 9/12/2017 9:02 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)	B	-96,269	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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)	A	-700	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,311,062			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-142,612	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-13,350	CENTRAL SERVICES & SUPPLY	14.00	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	B	-6,776	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-123,262	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00			0		0.00	0	33.00
33.01	CREDENTIALING	B	-14,600	OTHER ADMIN & GENERAL	5.03	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8 | Date/Time Prepared: 9/12/2017 9:02 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	MISC REVENUE	B	-14,002	OTHER ADMIN & GENERAL	5.03	0	33.02
33.03	FITNESS CENTER	B	-54,774	OTHER ADMIN & GENERAL	5.03	0	33.03
33.04	MARKETING EXPENSE	A	-268,025	OTHER ADMIN & GENERAL	5.03	0	33.04
33.05	LOBBYING EXPENSE	A	-12,979	OTHER ADMIN & GENERAL	5.03	0	33.05
33.06	PROPERTY TAX	A	-24,811	OTHER ADMIN & GENERAL	5.03	0	33.06
33.07	ASSESSMENT TAX	A	-536,270	OTHER ADMIN & GENERAL	5.03	0	33.07
33.08	PHYSICIAN BENEFITS	A	-15,419	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.10	TELEPHONE SERVICES	A	-932	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	TELEPHONE SERVICES	A	-2,897	OTHER ADMIN & GENERAL	5.03	0	33.11
33.12	TELEPHONE SERVICES	A	-1,073	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.13	MARKETING BENEFITS	A	-11,223	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.17	EDUCATION MISC REVENUE	B	-1,730	NURSING ADMINISTRATION	13.00	0	33.17
33.18	MRI RENTAL INCOME	B	-12,726	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.19	PHYSICAL THERAPY RENTAL INCOME	B	-61,622	PHYSICAL THERAPY	66.00	0	33.19
33.20	DONATIONS	B	-3,422	OTHER ADMIN & GENERAL	5.03	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,730,536				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: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 9/12/2017 9:02 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	50.00	OPERATING ROOM	31,750	31,750	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	282,440	282,440	0	0	0	2.00
3.00	64.00	INTRAVENOUS THERAPY	1,000	1,000	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	12,000	0	12,000	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	116,400	116,400	0	0	0	5.00
6.00	91.00	EMERGENCY	624,048	405,070	218,978	0	0	6.00
7.00	91.00	EMERGENCY	47,871	0	47,871	0	0	7.00
8.00	91.00	EMERGENCY	111,266	111,266	0	0	0	8.00
9.00	91.00	EMERGENCY	363,136	363,136	0	0	0	9.00
10.00	5.03	OTHER ADMIN & GENERAL	5,828	0	5,828	0	0	10.00
200.00			1,595,739	1,311,062	284,677		0	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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	64.00	INTRAVENOUS THERAPY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	5.03	OTHER ADMIN & GENERAL	0	0	0	0	0	10.00
200.00			0	0	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	50.00	OPERATING ROOM	0	0	0	31,750		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	282,440		2.00
3.00	64.00	INTRAVENOUS THERAPY	0	0	0	1,000		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	116,400		5.00
6.00	91.00	EMERGENCY	0	0	0	405,070		6.00
7.00	91.00	EMERGENCY	0	0	0	0		7.00
8.00	91.00	EMERGENCY	0	0	0	111,266		8.00
9.00	91.00	EMERGENCY	0	0	0	363,136		9.00
10.00	5.03	OTHER ADMIN & GENERAL	0	0	0	0		10.00
200.00			0	0	0	1,311,062		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/12/2017 9:02 am
		Physical Therapy	Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.38	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	400.00	7,112.42	1,380.28	3,262.48	0.00		9.00
10.00	AHSEA (see instructions)	92.33	80.29	39.14	16.00	0.00		10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.15	40.15	19.57				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						36,932	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						571,056	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						54,024	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						662,012	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						52,200	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						714,212	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						714,212	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						14,655	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						14,655	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						1,964	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						16,619	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						16,619	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/12/2017 9:02 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.29	39.14	16.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	714,212		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	16,619		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	730,831		63.00
64.00	Total cost of outside supplier services (from your records)	690,488		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	14,655		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,964		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	16,619		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,964		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,964		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/12/2017 9:02 am

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.38	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	12,496.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	63.04	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	31.52	31.52	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	787,764	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	787,764	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	787,764	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	787,764	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	11,505	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	11,505	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,964	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	13,469	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	13,469	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/12/2017 9:02 am

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	63.04	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		787,764	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		13,469	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		801,233	63.00
64.00	Total cost of outside supplier services (from your records)		776,567	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		11,505	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,964	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		13,469	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,964	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		1,964	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/12/2017 9:02 am
		Occupational Therapy	Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.38	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	659.32	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.09	0.00	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.05	38.05	0.00				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						50,168	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						50,168	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						50,168	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						76.09	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						59,350	22.00
23.00	Total salary equivalency (see instructions)						59,350	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						13,888	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						13,888	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						1,964	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						15,852	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						15,852	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/12/2017 9:02 am
		Occupational Therapy	Cost

		1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.09	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	59,350	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	15,852	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	75,202	63.00
64.00	Total cost of outside supplier services (from your records)	71,894	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,888	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,964	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	15,852	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,964	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,964	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,431,390	1,431,390				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,001,781		1,001,781			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,466,629	4,468	303	4,471,400		4.00
5.01	00570	ADMITTING	485,594	8,507	1,927	172,649	668,677	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	765,791	37,825	2,575	182,432	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	2,739,953	351,349	261,872	507,394	0	5.03
7.00	00700	OPERATION OF PLANT	1,345,456	126,636	18,357	140,413	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	89,087	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	394,090	8,450	501	129,325	0	9.00
10.00	01000	DIETARY	150,540	32,239	2,255	34,193	0	10.00
11.00	01100	CAFETERIA	186,122	20,509	0	74,666	0	11.00
13.00	01300	NURSING ADMINISTRATION	266,601	16,313	1,610	65,108	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	139,057	14,122	1,084	48,732	0	14.00
15.00	01500	PHARMACY	1,419,009	10,426	13,797	68,989	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	589,246	20,280	3,109	176,598	0	16.00
17.00	01700	SOCIAL SERVICE	239,042	2,191	0	80,060	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,830,200	118,816	137,764	620,941	35,014	30.00
31.00	03100	INTENSIVE CARE UNIT	17,099	23,846	3,461	1,725	265	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,567,544	107,702	298,167	327,040	74,640	50.00
53.00	05300	ANESTHESIOLOGY	692	0	13,106	0	10,513	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,170,472	72,312	154,303	247,192	179,866	54.00
60.00	06000	LABORATORY	1,562,063	26,567	17,195	262,140	114,635	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	87,001	3,094	830	3,877	1,699	62.00
64.00	06400	INTRAVENOUS THERAPY	235,836	15,897	945	81,962	6,775	64.00
65.00	06500	RESPIRATORY THERAPY	902,965	52,877	416	25,681	19,639	65.00
66.00	06600	PHYSICAL THERAPY	677,027	37,266	3,200	0	31,948	66.00
67.00	06700	OCCUPATIONAL THERAPY	76,869	3,666	315	0	3,147	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,977	0	0	0	5,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	206,939	0	0	0	8,889	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	106,622	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	40,569	1,891	0	14,179	334	90.01
91.00	09100	EMERGENCY	1,689,557	85,632	26,992	458,399	69,084	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,787,198	1,202,881	964,084	3,723,695	668,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,631	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	443,116	0	787	111,328	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	55,570	17,874	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	2,072,110	166,308	19,036	636,377	0	194.03
194.04	07954	340B PHARMACY	11,420	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	29,313,844	1,431,390	1,001,781	4,471,400	668,677	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	988,623					5.02
5.03	00590	OTHER ADMIN & GENERAL	0	3,860,568	3,860,568			5.03
7.00	00700	OPERATION OF PLANT	0	1,630,862	247,358	1,878,220		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	89,087	13,512	0	102,599	8.00
9.00	00900	HOUSEKEEPING	0	532,366	80,746	17,584	0	9.00
10.00	01000	DIETARY	0	219,227	33,251	67,086	0	10.00
11.00	01100	CAFETERIA	0	281,297	42,665	42,677	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	349,632	53,030	33,945	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	202,995	30,789	29,385	0	14.00
15.00	01500	PHARMACY	0	1,512,221	229,363	21,696	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	789,233	119,705	42,200	0	16.00
17.00	01700	SOCIAL SERVICE	0	321,293	48,731	4,560	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,060	2,793,795	423,743	247,242	25,622	30.00
31.00	03100	INTENSIVE CARE UNIT	387	46,783	7,096	49,621	143	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	108,845	2,483,938	376,746	224,116	23,086	50.00
53.00	05300	ANESTHESIOLOGY	15,331	39,642	6,013	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	262,293	3,086,438	468,123	150,473	20,777	54.00
60.00	06000	LABORATORY	167,169	2,149,769	326,062	55,284	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,478	98,979	15,012	6,437	0	62.00
64.00	06400	INTRAVENOUS THERAPY	9,879	351,294	53,282	33,081	0	64.00
65.00	06500	RESPIRATORY THERAPY	31,810	1,033,388	156,737	110,031	0	65.00
66.00	06600	PHYSICAL THERAPY	46,588	796,029	120,736	77,546	10,293	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,589	88,586	13,436	7,629	1,014	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,177	26,761	4,059	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,962	228,790	34,701	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155,483	262,105	39,754	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	488	57,461	8,715	3,934	0	90.01
91.00	09100	EMERGENCY	111,084	2,440,748	370,196	178,190	21,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	988,623	25,773,287	3,323,561	1,402,717	102,599	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,631	1,006	13,799	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	555,231	84,214	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	73,444	11,139	115,634	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,893,831	438,916	346,070	0	194.03
194.04	07954	340B PHARMACY	0	11,420	1,732	0	0	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	988,623	29,313,844	3,860,568	1,878,220	102,599	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	630,696					9.00
10.00	01000	DIETARY	22,740	342,304				10.00
11.00	01100	CAFETERIA	14,466	0	381,105			11.00
13.00	01300	NURSING ADMINISTRATION	11,506	0	12,319	460,432		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,961	0	7,068	0	280,198	14.00
15.00	01500	PHARMACY	7,354	0	7,169	3,028	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,305	0	18,479	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,546	0	5,857	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,807	261,622	82,195	211,980	0	30.00
31.00	03100	INTENSIVE CARE UNIT	16,820	370	12,117	1,185	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,968	27,963	26,456	89,181	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,006	0	19,085	0	0	54.00
60.00	06000	LABORATORY	18,739	0	38,411	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,182	0	565	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	11,213	28,375	14,036	12,201	0	64.00
65.00	06500	RESPIRATORY THERAPY	37,297	0	4,867	5,589	0	65.00
66.00	06600	PHYSICAL THERAPY	26,286	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,586	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	280,198	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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	1,333	0	1,919	0	0	90.01
91.00	09100	EMERGENCY	60,401	23,974	88,677	137,268	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	469,516	342,304	339,220	460,432	280,198	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,677	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	39,196	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	117,307	0	41,885	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	630,696	342,304	381,105	460,432	280,198	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,780,831					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	983,922				16.00
17.00	01700	SOCIAL SERVICE	0	0	381,987			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	187,004	379,710	4,696,720	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	2,277	136,412	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	61,507	0	3,388,961	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	45,655	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	88,822	0	3,884,724	0	54.00
60.00	06000	LABORATORY	0	136,194	0	2,724,459	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	123,175	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	124,733	0	628,215	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,877	0	1,354,786	0	65.00
66.00	06600	PHYSICAL THERAPY	0	28,512	0	1,059,402	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,814	0	116,065	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	311,018	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	263,491	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,780,831	0	0	2,082,690	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	0	0	73,362	0	90.01
91.00	09100	EMERGENCY	0	347,459	0	3,668,577	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,780,831	983,922	381,987	24,557,712	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	26,113	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	639,445	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	239,413	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	0	3,838,009	0	194.03
194.04	07954	340B PHARMACY	0	0	0	13,152	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,780,831	983,922	381,987	29,313,844	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,696,720		30.00
31.00	03100	INTENSIVE CARE UNIT	136,412		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,388,961		50.00
53.00	05300	ANESTHESIOLOGY	45,655		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,884,724		54.00
60.00	06000	LABORATORY	2,724,459		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	123,175		62.00
64.00	06400	INTRAVENOUS THERAPY	628,215		64.00
65.00	06500	RESPIRATORY THERAPY	1,354,786		65.00
66.00	06600	PHYSICAL THERAPY	1,059,402		66.00
67.00	06700	OCCUPATIONAL THERAPY	116,065		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	311,018		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	263,491		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,082,690		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	04950	DIABETIC SERVICES	73,362		90.01
91.00	09100	EMERGENCY	3,668,577		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,557,712		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,113		190.00
194.00	07950	OCCUPATIONAL HEALTH	639,445		194.00
194.01	07951	FOUNDATION	0		194.01
194.02	07952	PHYSICIANS CLINICS	239,413		194.02
194.03	07953	HEALTH & WELLNESS CENTER	3,838,009		194.03
194.04	07954	340B PHARMACY	13,152		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	29,313,844		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,468	303	4,771	4,771	4.00
5.01	00570	ADMITTING	0	8,507	1,927	10,434	184	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	37,825	2,575	40,400	195	5.02
5.03	00590	OTHER ADMIN & GENERAL	0	351,349	261,872	613,221	542	5.03
7.00	00700	OPERATION OF PLANT	0	126,636	18,357	144,993	150	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,450	501	8,951	138	9.00
10.00	01000	DIETARY	0	32,239	2,255	34,494	37	10.00
11.00	01100	CAFETERIA	0	20,509	0	20,509	80	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,313	1,610	17,923	70	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,122	1,084	15,206	52	14.00
15.00	01500	PHARMACY	0	10,426	13,797	24,223	74	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,280	3,109	23,389	189	16.00
17.00	01700	SOCIAL SERVICE	0	2,191	0	2,191	85	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	118,816	137,764	256,580	663	30.00
31.00	03100	INTENSIVE CARE UNIT	0	23,846	3,461	27,307	2	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	107,702	298,167	405,869	349	50.00
53.00	05300	ANESTHESIOLOGY	0	0	13,106	13,106	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	72,312	154,303	226,615	264	54.00
60.00	06000	LABORATORY	0	26,567	17,195	43,762	280	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,094	830	3,924	4	62.00
64.00	06400	INTRAVENOUS THERAPY	0	15,897	945	16,842	88	64.00
65.00	06500	RESPIRATORY THERAPY	0	52,877	416	53,293	27	65.00
66.00	06600	PHYSICAL THERAPY	0	37,266	3,200	40,466	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,666	315	3,981	0	67.00
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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	1,891	0	1,891	15	90.01
91.00	09100	EMERGENCY	0	85,632	26,992	112,624	489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,202,881	964,084	2,166,965	3,977	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,631	0	6,631	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	787	787	119	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	55,570	17,874	73,444	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	166,308	19,036	185,344	675	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,431,390	1,001,781	2,433,171	4,771	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	10,618					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	40,595				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	613,763			5.03
7.00	00700	OPERATION OF PLANT	0	0	39,325	184,468		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	2,148	0	2,148	8.00
9.00	00900	HOUSEKEEPING	0	0	12,837	1,727	0	9.00
10.00	01000	DIETARY	0	0	5,286	6,589	0	10.00
11.00	01100	CAFETERIA	0	0	6,783	4,192	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	8,431	3,334	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4,895	2,886	0	14.00
15.00	01500	PHARMACY	0	0	36,464	2,131	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	19,031	4,145	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	7,747	448	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	557	2,096	67,367	24,283	537	30.00
31.00	03100	INTENSIVE CARE UNIT	4	16	1,128	4,874	3	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,188	4,468	59,895	22,011	483	50.00
53.00	05300	ANESTHESIOLOGY	167	629	956	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,841	10,780	74,431	14,779	435	54.00
60.00	06000	LABORATORY	1,824	6,862	51,837	5,430	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	27	102	2,387	632	0	62.00
64.00	06400	INTRAVENOUS THERAPY	108	406	8,471	3,249	0	64.00
65.00	06500	RESPIRATORY THERAPY	313	1,306	24,918	10,807	0	65.00
66.00	06600	PHYSICAL THERAPY	508	1,912	19,195	7,616	215	66.00
67.00	06700	OCCUPATIONAL THERAPY	50	188	2,136	749	21	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89	336	645	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	141	532	5,517	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,697	6,382	6,320	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	5	20	1,386	386	0	90.01
91.00	09100	EMERGENCY	1,099	4,560	58,854	17,501	454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,618	40,595	528,390	137,769	2,148	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	160	1,355	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	13,388	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	1,771	11,357	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	69,779	33,987	0	194.03
194.04	07954	340B PHARMACY	0	0	275	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	10,618	40,595	613,763	184,468	2,148	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	23,653					9.00
10.00	01000	DIETARY	853	47,259				10.00
11.00	01100	CAFETERIA	543	0	32,107			11.00
13.00	01300	NURSING ADMINISTRATION	432	0	1,038	31,228		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	374	0	595	0	24,008	14.00
15.00	01500	PHARMACY	276	0	604	205	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	536	0	1,557	0	0	16.00
17.00	01700	SOCIAL SERVICE	58	0	493	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,143	36,120	6,925	14,377	0	30.00
31.00	03100	INTENSIVE CARE UNIT	631	51	1,021	80	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,849	3,861	2,229	6,049	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,913	0	1,608	0	0	54.00
60.00	06000	LABORATORY	703	0	3,236	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	82	0	48	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	421	3,917	1,182	828	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,399	0	410	379	0	65.00
66.00	06600	PHYSICAL THERAPY	986	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	97	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	24,008	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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	50	0	162	0	0	90.01
91.00	09100	EMERGENCY	2,265	3,310	7,470	9,310	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,611	47,259	28,578	31,228	24,008	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	175	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	1,470	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	4,397	0	3,529	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,653	47,259	32,107	31,228	24,008	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	63,977					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,847				16.00
17.00	01700	SOCIAL SERVICE	0	0	11,022			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,284	10,956	432,888	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	66	35,183	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,054	0	512,305	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,858	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,410	0	338,076	0	54.00
60.00	06000	LABORATORY	0	6,761	0	120,695	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	7,206	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	6,192	0	41,704	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	341	0	93,193	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,415	0	72,313	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	140	0	7,362	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,078	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,190	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,977	0	0	78,376	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	0	0	3,915	0	90.01
91.00	09100	EMERGENCY	0	17,250	0	235,186	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,977	48,847	11,022	2,024,528	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8,321	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	14,294	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	88,042	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	0	297,711	0	194.03
194.04	07954	340B PHARMACY	0	0	0	275	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	63,977	48,847	11,022	2,433,171	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	432,888		30.00
31.00	03100	INTENSIVE CARE UNIT	35,183		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	512,305		50.00
53.00	05300	ANESTHESIOLOGY	14,858		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	338,076		54.00
60.00	06000	LABORATORY	120,695		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,206		62.00
64.00	06400	INTRAVENOUS THERAPY	41,704		64.00
65.00	06500	RESPIRATORY THERAPY	93,193		65.00
66.00	06600	PHYSICAL THERAPY	72,313		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,362		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,078		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,190		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,376		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	04950	DIABETIC SERVICES	3,915		90.01
91.00	09100	EMERGENCY	235,186		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,024,528		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,321		190.00
194.00	07950	OCCUPATIONAL HEALTH	14,294		194.00
194.01	07951	FOUNDATION	0		194.01
194.02	07952	PHYSICIANS CLINICS	88,042		194.02
194.03	07953	HEALTH & WELLNESS CENTER	297,711		194.03
194.04	07954	340B PHARMACY	275		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,433,171		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,943					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		981,480				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312	297	12,025,280			4.00
5.01	00570	ADMITTING	594	1,888	464,318	60,465,132		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,641	2,523	490,629	0	61,302,933	5.02
5.03	00590	OTHER ADMIN & GENERAL	24,532	256,565	1,364,576	0	0	5.03
7.00	00700	OPERATION OF PLANT	8,842	17,985	377,625	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	590	491	347,805	0	0	9.00
10.00	01000	DIETARY	2,251	2,209	91,957	0	0	10.00
11.00	01100	CAFETERIA	1,432	0	200,806	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,139	1,577	175,099	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	986	1,062	131,059	0	0	14.00
15.00	01500	PHARMACY	728	13,517	185,537	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,416	3,046	474,940	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	215,312	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,296	134,972	1,669,945	3,166,139	3,166,139	30.00
31.00	03100	INTENSIVE CARE UNIT	1,665	3,391	4,638	24,000	24,000	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,520	292,125	879,534	6,749,243	6,749,243	50.00
53.00	05300	ANESTHESIOLOGY	0	12,840	0	950,663	950,663	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,049	151,176	664,792	16,264,718	16,264,718	54.00
60.00	06000	LABORATORY	1,855	16,847	704,993	10,365,809	10,365,809	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	216	813	10,427	153,654	153,654	62.00
64.00	06400	INTRAVENOUS THERAPY	1,110	926	220,427	612,582	612,582	64.00
65.00	06500	RESPIRATORY THERAPY	3,692	408	69,067	1,775,843	1,972,457	65.00
66.00	06600	PHYSICAL THERAPY	2,602	3,135	0	2,888,843	2,888,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	256	309	0	284,542	284,542	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	507,029	507,029	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	803,765	803,765	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,641,165	9,641,165	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	132	0	38,132	30,246	30,246	90.01
91.00	09100	EMERGENCY	5,979	26,445	1,232,809	6,246,891	6,888,078	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	83,988	944,547	10,014,427	60,465,132	61,302,933	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	463	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	771	299,402	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	3,880	17,512	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	11,612	18,650	1,711,451	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	1,431,390	1,001,781	4,471,400	668,677	988,623	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.322064	1.020684	0.371833	0.011059	0.016127	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,771	10,618	40,595	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000397	0.000176	0.000662	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL	-3,860,568	25,453,276				5.03
7.00	00700	OPERATION OF PLANT	0	1,630,862	63,022			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	89,087	0	134,920		8.00
9.00	00900	HOUSEKEEPING	0	532,366	590	0	62,432	9.00
10.00	01000	DIETARY	0	219,227	2,251	0	2,251	10.00
11.00	01100	CAFETERIA	0	281,297	1,432	0	1,432	11.00
13.00	01300	NURSING ADMINISTRATION	0	349,632	1,139	0	1,139	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	202,995	986	0	986	14.00
15.00	01500	PHARMACY	0	1,512,221	728	0	728	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	789,233	1,416	0	1,416	16.00
17.00	01700	SOCIAL SERVICE	0	321,293	153	0	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,793,795	8,296	33,696	8,296	30.00
31.00	03100	INTENSIVE CARE UNIT	0	46,783	1,665	188	1,665	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,483,938	7,520	30,358	7,520	50.00
53.00	05300	ANESTHESIOLOGY	0	39,642	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,086,438	5,049	27,322	5,049	54.00
60.00	06000	LABORATORY	0	2,149,769	1,855	0	1,855	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	98,979	216	0	216	62.00
64.00	06400	INTRAVENOUS THERAPY	0	351,294	1,110	0	1,110	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,033,388	3,692	0	3,692	65.00
66.00	06600	PHYSICAL THERAPY	0	796,029	2,602	13,535	2,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	88,586	256	1,333	256	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,761	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	228,790	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	262,105	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	57,461	132	0	132	90.01
91.00	09100	EMERGENCY	0	2,440,748	5,979	28,488	5,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,860,568	21,912,719	47,067	134,920	46,477	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,631	463	0	463	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	555,231	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	73,444	3,880	0	3,880	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,893,831	11,612	0	11,612	194.03
194.04	07954	340B PHARMACY	0	11,420	0	0	0	194.04
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)		3,860,568	1,878,220	102,599	630,696	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.151673	29.802609	0.760443	10.102127	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		613,763	184,468	2,148	23,653	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.024113	2.927041	0.015921	0.378860	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	8,324					10.00
11.00	01100	CAFETERIA	0	18,871				11.00
13.00	01300	NURSING ADMINISTRATION	0	610	240,875			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	350	0	100		14.00
15.00	01500	PHARMACY	0	355	1,584	0	1,064,916	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	915	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	290	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,362	4,070	110,897	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9	600	620	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	680	1,310	46,655	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	945	0	0	0	54.00
60.00	06000	LABORATORY	0	1,902	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	28	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	690	695	6,383	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	241	2,924	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	100	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	1,064,916	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	95	0	0	0	90.01
91.00	09100	EMERGENCY	583	4,391	71,812	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,324	16,797	240,875	100	1,064,916	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,074	0	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	342,304	381,105	460,432	280,198	1,780,831	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.122537	20.195273	1.911498	2,801.980000	1.672274	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,259	32,107	31,228	24,008	63,977	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.677439	1.701394	0.129644	240.080000	0.060077	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/12/2017 9:02 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,265			16.00
17.00	01700	SOCIAL SERVICE	0	1,342		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	14,685	1,334		30.00
31.00	03100	INTENSIVE CARE UNIT	0	8		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,830	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,975	0		54.00
60.00	06000	LABORATORY	10,695	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	9,795	0		64.00
65.00	06500	RESPIRATORY THERAPY	540	0		65.00
66.00	06600	PHYSICAL THERAPY	2,239	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	221	0		67.00
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	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	DIABETIC SERVICES	0	0		90.01
91.00	09100	EMERGENCY	27,285	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,265	1,342		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	0		194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0		194.03
194.04	07954	340B PHARMACY	0	0		194.04
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)	983,922	381,987		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.734382	284.640089		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,847	11,022		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.632201	8.213115		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | 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	4,696,720		4,696,720	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	136,412		136,412	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,388,961		3,388,961	0	0	50.00
53.00	05300	ANESTHESIOLOGY	45,655		45,655	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,884,724		3,884,724	0	0	54.00
60.00	06000	LABORATORY	2,724,459		2,724,459	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	123,175		123,175	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	628,215		628,215	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,354,786	0	1,354,786	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,059,402	0	1,059,402	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	116,065	0	116,065	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	311,018		311,018	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	263,491		263,491	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,082,690		2,082,690	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	04950	DIABETIC SERVICES	73,362		73,362	0	0	90.01
91.00	09100	EMERGENCY	3,668,577		3,668,577	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,086,573		1,086,573		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,644,285	0	25,644,285	0	0	200.00
201.00		Less Observation Beds	1,086,573		1,086,573		0	201.00
202.00		Total (see instructions)	24,557,712	0	24,557,712	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | 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	1,857,000		1,857,000			30.00
31.00	03100	INTENSIVE CARE UNIT	24,000		24,000			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	842,673	5,906,570	6,749,243	0.502125	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	86,644	864,019	950,663	0.048024	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,178	15,612,540	16,264,718	0.238844	0.000000	54.00
60.00	06000	LABORATORY	727,424	9,638,385	10,365,809	0.262831	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,040	114,614	153,654	0.801639	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	612,582	612,582	1.025520	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	463,840	1,312,003	1,775,843	0.762897	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	147,745	2,741,098	2,888,843	0.366722	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	284,542	284,542	0.407901	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	327,744	179,285	507,029	0.613413	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	532,010	271,755	803,765	0.327821	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,431,710	8,209,455	9,641,165	0.216021	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04950	DIABETIC SERVICES	0	30,246	30,246	2.425511	0.000000	90.01
91.00	09100	EMERGENCY	0	6,246,891	6,246,891	0.587264	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,309,139	1,309,139	0.829991	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,132,008	53,333,124	60,465,132			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,132,008	53,333,124	60,465,132			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
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		
90.00	09000	CLINIC	0.000000	90.00
90.01	04950	DIABETIC SERVICES	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/12/2017 9:02 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	4,696,720		4,696,720	0	4,696,720	30.00
31.00	03100	INTENSIVE CARE UNIT	136,412		136,412	0	136,412	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,388,961		3,388,961	0	3,388,961	50.00
53.00	05300	ANESTHESIOLOGY	45,655		45,655	0	45,655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,884,724		3,884,724	0	3,884,724	54.00
60.00	06000	LABORATORY	2,724,459		2,724,459	0	2,724,459	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	123,175		123,175	0	123,175	62.00
64.00	06400	INTRAVENOUS THERAPY	628,215		628,215	0	628,215	64.00
65.00	06500	RESPIRATORY THERAPY	1,354,786	0	1,354,786	0	1,354,786	65.00
66.00	06600	PHYSICAL THERAPY	1,059,402	0	1,059,402	0	1,059,402	66.00
67.00	06700	OCCUPATIONAL THERAPY	116,065	0	116,065	0	116,065	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	311,018		311,018	0	311,018	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	263,491		263,491	0	263,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,082,690		2,082,690	0	2,082,690	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	04950	DIABETIC SERVICES	73,362		73,362	0	73,362	90.01
91.00	09100	EMERGENCY	3,668,577		3,668,577	0	3,668,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,086,573		1,086,573		1,086,573	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,644,285	0	25,644,285	0	25,644,285	200.00
201.00		Less Observation Beds	1,086,573		1,086,573		1,086,573	201.00
202.00		Total (see instructions)	24,557,712	0	24,557,712	0	24,557,712	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/12/2017 9:02 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	1,857,000		1,857,000			30.00
31.00	03100	INTENSIVE CARE UNIT	24,000		24,000			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	842,673	5,906,570	6,749,243	0.502125	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	86,644	864,019	950,663	0.048024	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,178	15,612,540	16,264,718	0.238844	0.000000	54.00
60.00	06000	LABORATORY	727,424	9,638,385	10,365,809	0.262831	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,040	114,614	153,654	0.801639	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	612,582	612,582	1.025520	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	463,840	1,312,003	1,775,843	0.762897	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	147,745	2,741,098	2,888,843	0.366722	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	284,542	284,542	0.407901	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	327,744	179,285	507,029	0.613413	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	532,010	271,755	803,765	0.327821	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,431,710	8,209,455	9,641,165	0.216021	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04950	DIABETIC SERVICES	0	30,246	30,246	2.425511	0.000000	90.01
91.00	09100	EMERGENCY	0	6,246,891	6,246,891	0.587264	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,309,139	1,309,139	0.829991	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,132,008	53,333,124	60,465,132			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,132,008	53,333,124	60,465,132			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/12/2017 9:02 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
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			
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	DIABETIC SERVICES	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part II Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Hospital | Cost

		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	512,305	6,749,243	0.075906	411,927	31,268	50.00
53.00	05300	ANESTHESIOLOGY	14,858	950,663	0.015629	41,205	644	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	338,076	16,264,718	0.020786	396,614	8,244	54.00
60.00	06000	LABORATORY	120,695	10,365,809	0.011644	468,638	5,457	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,206	153,654	0.046898	27,069	1,269	62.00
64.00	06400	INTRAVENOUS THERAPY	41,704	612,582	0.068079	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	93,193	1,775,843	0.052478	298,435	15,661	65.00
66.00	06600	PHYSICAL THERAPY	72,313	2,888,843	0.025032	82,259	2,059	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,362	284,542	0.025873	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,078	507,029	0.049461	230,312	11,391	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,190	803,765	0.007701	328,290	2,528	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,376	9,641,165	0.008129	777,210	6,318	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC SERVICES	3,915	30,246	0.129439	0	0	90.01
91.00	09100	EMERGENCY	235,186	6,246,891	0.037648	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	100,147	1,309,139	0.076498	0	0	92.00
200.00		Total (lines 50-199)	1,656,604	58,584,132		3,061,959	84,839	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,749,243	0.000000	0.000000	411,927	50.00
53.00	05300	ANESTHESIOLOGY	0	950,663	0.000000	0.000000	41,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,264,718	0.000000	0.000000	396,614	54.00
60.00	06000	LABORATORY	0	10,365,809	0.000000	0.000000	468,638	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	153,654	0.000000	0.000000	27,069	62.00
64.00	06400	INTRAVENOUS THERAPY	0	612,582	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,775,843	0.000000	0.000000	298,435	65.00
66.00	06600	PHYSICAL THERAPY	0	2,888,843	0.000000	0.000000	82,259	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	284,542	0.000000	0.000000	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	507,029	0.000000	0.000000	230,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	803,765	0.000000	0.000000	328,290	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,641,165	0.000000	0.000000	777,210	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	04950	DIABETIC SERVICES	0	30,246	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,246,891	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,309,139	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	58,584,132			3,061,959	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	04950	DIABETIC SERVICES	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Hospital | Cost

		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	0.502125	0	2,139,782	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.048024	0	311,013	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238844	0	4,760,086	0	0	54.00
60.00	06000	LABORATORY	0.262831	0	3,707,719	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.801639	0	72,249	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.025520	0	289,854	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.762897	0	528,218	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.366722	0	755,605	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.407901	0	68,819	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.613413	0	87,181	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327821	0	71,682	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.216021	0	4,503,848	437	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	2.425511	0	10,844	0	0	90.01
91.00	09100	EMERGENCY	0.587264	0	1,839,736	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.829991	0	571,549	0	0	92.00
200.00		Subtotal (see instructions)		0	19,718,185	437	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	19,718,185	437	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Hospital | Cost

		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	1,074,438	0		50.00
53.00	05300	ANESTHESIOLOGY	14,936	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,136,918	0		54.00
60.00	06000	LABORATORY	974,503	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,918	0		62.00
64.00	06400	INTRAVENOUS THERAPY	297,251	0		64.00
65.00	06500	RESPIRATORY THERAPY	402,976	0		65.00
66.00	06600	PHYSICAL THERAPY	277,097	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	28,071	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,478	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,499	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	972,926	94		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	DIABETIC SERVICES	26,302	0		90.01
91.00	09100	EMERGENCY	1,080,411	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	474,381	0		92.00
200.00		Subtotal (see instructions)	6,895,105	94		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,895,105	94		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Swing Beds - SNF

		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	0.502125	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.048024	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238844	0	0	0	0	54.00
60.00	06000	LABORATORY	0.262831	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.801639	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.025520	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.762897	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.366722	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.407901	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.613413	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327821	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.216021	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	2.425511	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.587264	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.829991	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Swing Beds - SNF

		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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
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	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	DIABETIC SERVICES	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | 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)	1,863	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,765	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)	1,334	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	98	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)	798	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)	98	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	169.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	169.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,696,720	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)	247,063	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,449,657	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,449,657	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)	2,521.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,011,798	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,011,798	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	136,412	8	17,051.50	7	119,361	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)	1,123,051	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,254,210	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)	247,063	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)	247,063	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)	431	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,521.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,086,573	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | 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	432,888	4,696,720	0.092168	1,086,573	100,147	90.00
91.00	Nursing School cost	0	4,696,720	0.000000	1,086,573	0	91.00
92.00	Allied health cost	0	4,696,720	0.000000	1,086,573	0	92.00
93.00	All other Medical Education	0	4,696,720	0.000000	1,086,573	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-3 | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | 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		1,037,400		30.00
31.00	03100	INTENSIVE CARE UNIT		21,000		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.502125	411,927	206,839	50.00
53.00	05300	ANESTHESIOLOGY	0.048024	41,205	1,979	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238844	396,614	94,729	54.00
60.00	06000	LABORATORY	0.262831	468,638	123,173	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.801639	27,069	21,700	62.00
64.00	06400	INTRAVENOUS THERAPY	1.025520	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.762897	298,435	227,675	65.00
66.00	06600	PHYSICAL THERAPY	0.366722	82,259	30,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.407901	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.613413	230,312	141,276	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327821	328,290	107,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.216021	777,210	167,894	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	04950	DIABETIC SERVICES	2.425511	0	0	90.01
91.00	09100	EMERGENCY	0.587264	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.829991	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,061,959	1,123,051	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)		3,061,959		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-3 | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Swing Beds - SNF

		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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.502125	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.048024	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238844	4,345	1,038	54.00
60.00	06000	LABORATORY	0.262831	19,988	5,253	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.801639	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.025520	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.762897	28,154	21,479	65.00
66.00	06600	PHYSICAL THERAPY	0.366722	36,676	13,450	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.407901	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.613413	4,356	2,672	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327821	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.216021	63,122	13,636	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	04950	DIABETIC SERVICES	2.425511	0	0	90.01
91.00	09100	EMERGENCY	0.587264	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.829991	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		156,641	57,528	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)		156,641		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part B Date/Time Prepared: 9/12/2017 9:02 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,895,199	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,895,199	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6,964,151	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	30,845	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,259,723	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)	3,673,583	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)	3,673,583	30.00
31.00	Primary payer payments	1,613	31.00
32.00	Subtotal (line 30 minus line 31)	3,671,970	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)	550,390	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	357,754	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	403,825	36.00
37.00	Subtotal (see instructions)	4,029,724	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,029,724	40.00
40.01	Sequestration adjustment (see instructions)	80,594	40.01
41.00	Interim payments	4,326,114	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-376,984	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: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,823,643		4,326,114	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	11/11/2016	274,300		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)		274,300		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)		3,097,943		4,326,114	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		104,717		376,984	6.02
7.00	Total Medicare program liability (see instructions)		2,993,226		3,949,130	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: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Swing Beds - SNF

		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		274,365		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)		274,365		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		26,488		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		300,853		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: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet E-1 Part II Date/Time Prepared: 9/12/2017 9:02 am
	Title XVIII	Hospital	Cost

		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	492	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	805	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	166	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,342	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	60,465,132	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,204,119	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet E-2 | Date/Time Prepared: 9/12/2017 9:02 am

Title XVIII | Swing Beds - SNF

		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)	249,534	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)	58,103	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	98	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)	307,637	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	307,637	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)	307,637	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	644	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)	306,993	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	410A RURAL DEMONSTRATION PROJECT	0		16.55
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)	306,993	0	19.00
19.01	Sequestration adjustment (see instructions)	6,140	0	19.01
20.00	Interim payments	274,365	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)	26,488	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1312	Period: From 05/01/2016 To 04/30/2017	Worksheet E-3 Part V Date/Time Prepared: 9/12/2017 9:02 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,254,210	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,254,210	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,286,752	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,286,752	19.00
20.00	Deductibles (exclude professional component)	272,384	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,014,368	22.00
23.00	Coinsurance	644	23.00
24.00	Subtotal (line 22 minus line 23)	3,013,724	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	62,443	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	40,588	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,435	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,054,312	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,054,312	30.00
30.01	Sequestration adjustment (see instructions)	61,086	30.01
31.00	Interim payments	3,097,943	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-104,717	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G | Date/Time Prepared: 9/12/2017 9:02 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	9,828,494	0	0	0	1.00
2.00	Temporary investments	8,547,661	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,451,330	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,412,758	0	0	0	6.00
7.00	Inventory	221,589	0	0	0	7.00
8.00	Prepaid expenses	926,819	0	0	0	8.00
9.00	Other current assets	46,258	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)	25,609,393	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,389,097	0	0	0	12.00
13.00	Land improvements	1,449,503	0	0	0	13.00
14.00	Accumulated depreciation	-1,067,696	0	0	0	14.00
15.00	Buildings	20,216,752	0	0	0	15.00
16.00	Accumulated depreciation	-8,692,939	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,578,220	0	0	0	19.00
20.00	Accumulated depreciation	-999,321	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	8,619,123	0	0	0	23.00
24.00	Accumulated depreciation	-5,968,353	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	3,991,023	0	0	0	27.00
28.00	Accumulated depreciation	-3,525,616	0	0	0	28.00
29.00	Minor equipment-nondepreciable	329,993	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,319,786	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	30,577	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	30,577	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45,959,756	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	951,205	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,206,570	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	525,036	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	548,764	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,231,575	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	7,523,478	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)	7,523,478	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,755,053	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	34,204,703				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)	34,204,703	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45,959,756	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G-1 | Date/Time Prepared: 9/12/2017 9:02 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		30,070,659		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,134,044				2.00
3.00	Total (sum of line 1 and line 2)		34,204,703		0		3.00
4.00		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)		34,204,703		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)		34,204,703		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			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: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/12/2017 9:02 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,740,600		1,740,600	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	116,400		116,400	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)	1,857,000		1,857,000	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	24,000		24,000	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)	24,000		24,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,881,000		1,881,000	17.00
18.00	Ancillary services	5,251,008	45,746,848	50,997,856	18.00
19.00	Outpatient services	0	7,586,276	7,586,276	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				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL CHARGES	0	2,985,575	2,985,575	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,132,008	56,318,699	63,450,707	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,044,380		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)		32,044,380		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G-3 | Date/Time Prepared: 9/12/2017 9:02 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	63,450,707	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,976,642	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,474,065	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,044,380	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,429,685	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	70,436	6.00
7.00	Income from investments	96,046	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	142,612	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	6,776	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	139,073	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT INCOME	429,173	24.00
24.01	340B INCOME	21,687	24.01
24.02	FITNESS CENTER	54,774	24.02
24.03	MISCELLANEOUS INCOME	63,442	24.03
24.04	UNREALIZED GAIN ON INVESTMENTS	682,454	24.04
25.00	Total other income (sum of lines 6-24)	1,706,473	25.00
26.00	Total (line 5 plus line 25)	4,136,158	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	2,114	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,114	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,134,044	29.00