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: 14-1332	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/22/2017 1:13 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/22/2017 Time: 1:13 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received: 12/01/2016
7. Contractor No. 06101
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 HILLSBORO AREA HOSPITAL (14-1332) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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.

Encryption Information

ECR: Date: 11/22/2017 Time: 1:13 pm
rVipBP3Qnnv0Nd4yW:xd3i0MRYFRO0
hCMib0DNXaE5pRYNVZO:20yf5OX7hC
QoxF0BClqB0keu7n

PI: Date: 11/22/2017 Time: 1:13 pm
:hb8mwxTVsXUNxCTmeVAuf61H5Bv60
w6XG10crh6dLZSY3cKh2NNKy9pR67v
FuEL0jXIhy03AMUJ

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

_____
Title

_____
Date

		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	99,208	-12,419	1	-127	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	202,107	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	301,315	-12,419	1	-127	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.

WIPFLi LLP

Accountant's Compilation Report

Board of Directors
Hillsboro Area Hospital, Inc.
Hillsboro, Illinois

Management is responsible for the accompanying Medicare Cost Report of Hillsboro Area Hospital, Inc., included in the accompanying prescribed form as of and for the year ended June 30, 2017. We have performed a compilation engagement in accordance with *Statements on Standards for Accounting and Review Services* promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the Medicare Cost Report included in the accompanying prescribed form nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on this Medicare Cost Report.

Other Matter

The Medicare Cost Report included in the accompanying prescribed form is intended to comply with the requirements of the Centers for Medicare and Medicaid Services and is not intended to be a presentation in accordance with accounting principles generally accepted in the United States.

Restriction on Use

Our report and the prescribed form are intended solely for the information and use of Hillsboro Area Hospital, Inc. and the Centers for Medicare and Medicaid Services and is not intended to be, and should not be, used by anyone other than these specified parties.

Wipfli LLP

Wipfli LLP

November 22, 2017
Eau Claire, Wisconsin

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2017 1:11 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1200 E. TREMONT	PO Box:			1.00
2.00	City: HILLSBORO	State: IL	Zip Code: 62049	County: MONTGOMERY	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	HILLSBORO AREA HOSPITAL	141332	99914	1	09/06/1975	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	HILLSBORO AREA HOSPITAL	14Z332	99914		04/01/2004	N	O	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
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
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)	07/01/2016	06/30/2017	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.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2017 1:11 pm

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

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

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2017 1:11 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 1:11 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2017 1:11 pm

		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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
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)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2017 1:11 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	53,576	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		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.	Y	5.02	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 1:11 pm

		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
161.10	CORF		N	N	N	161.10
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40
					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)						0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2016	06/30/2017	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2017 1:11 pm

		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)	Y			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	11/16/2017	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.	Y			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.	Y	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	10/03/2017	Y	10/03/2017	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: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/22/2017 1:11 pm

		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.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID		GOODMAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6082702962		DGOODMAN@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1332	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/22/2017 1:11 pm

		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.	CPA		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: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2017 1:11 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	21,240.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	21,240.00	0	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)		25	9,125	21,240.00	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
25.10	CMHC - CORF	99.10				0	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
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)		25				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: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2017 1:11 pm

	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)	651	36	885			1.00
2.00	HMO and other (see instructions)	65	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	1,076	0	1,102			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,727	36	1,987			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)	1,727	36	1,987	0.00	133.70	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
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	133.70	27.00
28.00	Observation Bed Days		0	417			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: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2017 1:11 pm

	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	217	17	301	1.00
2.00	HMO and other (see instructions)			20	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	217	17	301	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
25.10	CMHC - CORF	0.00					25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-7 | Date/Time Prepared: 11/22/2017 1:11 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	04/01/2004	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-7 | Date/Time Prepared: 11/22/2017 1:11 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1332	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/22/2017 1:11 pm

		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)	0.412064	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,241,606	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	7,785,015	6.00
7.00	Medicaid cost (line 1 times line 6)	3,207,924	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	694,962	0	694,962	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	286,369	0	286,369	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	286,369	0	286,369	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, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,126,701	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	232,415	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	357,561	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	769,140	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	442,081	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	728,450	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	728,450	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/22/2017 1:11 pm

		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		739,599	739,599	-122,592	617,007	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		955,075	955,075	10,511	965,586	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	89,835	2,502,850	2,592,685	0	2,592,685	4.00
5.01	00592	ADMINISTRATION & ACCOUNTING	345,708	933,440	1,279,148	0	1,279,148	5.01
5.02	00591	GENERAL	197,625	897,535	1,095,160	-47,282	1,047,878	5.02
5.03	00570	ADMITTING	159,401	15,869	175,270	0	175,270	5.03
5.04	00580	PATIENT ACCOUNTING	204,555	159,652	364,207	0	364,207	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	189,277	374,410	563,687	0	563,687	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	61,329	31,409	92,738	0	92,738	8.00
9.00	00900	HOUSEKEEPING	134,259	21,070	155,329	0	155,329	9.00
10.00	01000	DIETARY	129,058	130,800	259,858	0	259,858	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
13.01	01301	UR/QUALITY IMPROVEMENT	175,289	9,058	184,347	0	184,347	13.01
13.02	01302	NURSING ADMINISTRATION	244,738	9,123	253,861	0	253,861	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	37,329	3,249	40,578	0	40,578	14.02
15.00	01500	PHARMACY	0	887,859	887,859	-471,002	416,857	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	190,051	102,135	292,186	0	292,186	16.00
17.00	01700	SOCIAL SERVICE	0	716	716	0	716	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,053,690	201,892	1,255,582	-79	1,255,503	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	547,943	399,750	947,693	8,427	956,120	50.00
53.00	05300	ANESTHESIOLOGY	0	162,081	162,081	-49,307	112,774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	447,827	296,409	744,236	0	744,236	54.00
54.01	03040	ULTRA SOUND	0	207,007	207,007	0	207,007	54.01
56.00	05600	RADIOISOTOPE	77,134	385,618	462,752	0	462,752	56.00
60.00	06000	LABORATORY	521,332	697,036	1,218,368	0	1,218,368	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	136,142	35,292	171,434	-15,645	155,789	65.00
65.50	06501	SLEEP LAB	50,411	93,200	143,611	0	143,611	65.50
66.00	06600	PHYSICAL THERAPY	923,264	118,184	1,041,448	0	1,041,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,511	9,535	132,046	0	132,046	67.00
69.00	06900	ELECTROCARDIOLOGY	0	59,773	59,773	0	59,773	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	31,879	31,879	60,571	92,450	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	467,376	467,376	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	789,284	1,822,621	2,611,905	-341	2,611,564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,827,992	12,294,126	19,122,118	-159,363	18,962,755	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	690,325	477,243	1,167,568	159,363	1,326,931	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
200.00		TOTAL (SUM OF LINES 118-199)	7,518,317	12,771,369	20,289,686	0	20,289,686	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/22/2017 1:11 pm

		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	-302,550	314,457		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-107,306	858,280		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,714	2,590,971		4.00
5.01	00592	ADMINISTRATION & ACCOUNTING	-152,334	1,126,814		5.01
5.02	00591	GENERAL	-444,984	602,894		5.02
5.03	00570	ADMITTING	0	175,270		5.03
5.04	00580	PATIENT ACCOUNTING	0	364,207		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	563,687		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	92,738		8.00
9.00	00900	HOUSEKEEPING	0	155,329		9.00
10.00	01000	DIETARY	-46,895	212,963		10.00
11.00	01100	CAFETERIA	0	0		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
13.01	01301	UR/QUALITY IMPROVEMENT	0	184,347		13.01
13.02	01302	NURSING ADMINISTRATION	0	253,861		13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
14.01	01401	PURCHASING	0	0		14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	40,578		14.02
15.00	01500	PHARMACY	0	416,857		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,491	287,695		16.00
17.00	01700	SOCIAL SERVICE	0	716		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,255,503		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	956,120		50.00
53.00	05300	ANESTHESIOLOGY	-99,111	13,663		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-262	743,974		54.00
54.01	03040	ULTRA SOUND	0	207,007		54.01
56.00	05600	RADIOISOTOPE	0	462,752		56.00
60.00	06000	LABORATORY	-57,959	1,160,409		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	155,789		65.00
65.50	06501	SLEEP LAB	-21,300	122,311		65.50
66.00	06600	PHYSICAL THERAPY	-9,750	1,031,698		66.00
67.00	06700	OCCUPATIONAL THERAPY	-4,014	128,032		67.00
69.00	06900	ELECTROCARDIOLOGY	-33,985	25,788		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-468	91,982		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	467,376		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,082,325	1,529,239		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,369,448	16,593,307		118.00
		NONREIMBURSABLE COST CENTERS				
192.02	19201	ASSISTED LIVING	-632	1,326,299		192.02
192.03	19202	CARDIAC REHAB	0	0		192.03
200.00		TOTAL (SUM OF LINES 118-199)	-2,370,080	17,919,606		200.00

RECLASSIFICATIONS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/22/2017 1:11 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS DRUG COST FROM PHARMACY				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	467,376	1.00
	TOTALS		0	467,376	
	B - TO RECLASS MED SUPPLY FROM PHARMACY				
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	1,526	1.00
	TOTALS		0	1,526	
	C - TO RECLASS MED SUPPLY FROM OR				
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	39,161	1.00
	TOTALS		0	39,161	
	D - TO RECLASS OXGEN FROM RT TO MED SUP				
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	15,645	1.00
	TOTALS		0	15,645	
	E - TO RECLASS INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	18,440	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	28,842	2.00
	TOTALS		0	47,282	
	F - TO RECLASS DEPRECIATION				
1.00	ASSISTED LIVING	192.02	0	159,363	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	159,363	
	G - TO RECLASS ONCALL EXPENSE				
1.00	OPERATING ROOM	50.00	0	49,200	1.00
	TOTALS		0	49,200	
	H - TO RECLASS IV THERAPY TO MED SUP				
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	4,239	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	4,239	
500.00	Grand Total: Increases		0	783,792	500.00

RECLASSIFICATIONS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/22/2017 1:11 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS DRUG COST FROM PHARMACY						
1.00	PHARMACY	15.00	0	467,376	0		1.00
	TOTALS		0	467,376			
	B - TO RECLASS MED SUPPLY FROM PHARMACY						
1.00	PHARMACY	15.00	0	1,526	0		1.00
	TOTALS		0	1,526			
	C - TO RECLASS MED SUPPLY FROM OR						
1.00	OPERATING ROOM	50.00	0	39,161	0		1.00
	TOTALS		0	39,161			
	D - TO RECLASS OXGEN FROM RT TO MED SUP						
1.00	RESPIRATORY THERAPY	65.00	0	15,645	0		1.00
	TOTALS		0	15,645			
	E - TO RECLASS INSURANCE						
1.00	GENERAL	5.02	0	47,282	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	47,282			
	F - TO RECLASS DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	141,032	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	18,331	9		2.00
	TOTALS		0	159,363			
	G - TO RECLASS ONCALL EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	49,200	0		1.00
	TOTALS		0	49,200			
	H - TO RECLASS IV THERAPY TO MED SUP						
1.00	PHARMACY	15.00	0	2,100	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	79	0		2.00
3.00	OPERATING ROOM	50.00	0	1,612	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	107	0		4.00
5.00	EMERGENCY	91.00	0	341	0		5.00
	TOTALS		0	4,239			
500.00	Grand Total: Decreases		0	783,792			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/22/2017 1:11 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	265,747	29,363	0	29,363	0	1.00
2.00	Land Improvements	1,687,647	0	0	0	0	2.00
3.00	Buildings and Fixtures	16,506,789	314,513	0	314,513	280,223	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	164,333	0	0	0	0	5.00
6.00	Movable Equipment	12,080,366	513,323	0	513,323	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,704,882	857,199	0	857,199	280,223	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	30,704,882	857,199	0	857,199	280,223	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	295,110	0	1.00
2.00	Land Improvements	1,687,647	0	2.00
3.00	Buildings and Fixtures	16,541,079	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	164,333	0	5.00
6.00	Movable Equipment	12,593,689	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,281,858	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,281,858	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/22/2017 1:11 pm

	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	739,599	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	955,075	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,694,674	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	0	739,599	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	955,075	2.00
3.00	Total (sum of lines 1-2)	0	1,694,674	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2017 1:11 pm

	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	18,228,727	0	18,228,727	0.588275	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,758,021	0	12,758,021	0.411725	0	2.00
3.00	Total (sum of lines 1-2)	30,986,748	0	30,986,748	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	296,017	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	829,438	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,125,455	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	0	18,440	0	0	314,457	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	28,842	0	0	858,280	2.00
3.00	Total (sum of lines 1-2)	0	47,282	0	0	1,172,737	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/22/2017 1:11 pm

	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	-291,126	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-4,066	ADMINISTRATION & ACCOUNTING	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-6,693	ADMINISTRATION & ACCOUNTING	5.01	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	-251	GENERAL	5.02	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	-1,195,569			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	-42,824	DIETARY	10.00	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	-468	MEDICAL SUPPLIES CHARGED TO PAT	71.00	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	-4,491	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	NONPHYSICIAN ANESTHETISTS	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/22/2017 1:11 pm

	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	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-103,479	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	NUTRITIONAL SERVICES	A	-4,071	DIETARY	10.00	0	33.00
34.00	CRNA	A	-99,111	ANESTHESIOLOGY	53.00	0	34.00
35.00	LOBBYING PORTION OF DUES	A	-15,709	ADMINISTRATION & ACCOUNTING	5.01	0	35.00
36.00	MARKETING COSTS	A	-87,913	GENERAL	5.02	0	36.00
40.00			0		0.00	0	40.00
41.00	EMPLOYEE MEALS - ALF	B	-632	ASSISTED LIVING	192.02	0	41.00
42.00	OTHER MISCELLANEOUS	B	-262	RADIOLOGY-DIAGNOSTIC	54.00	0	42.00
43.00	ALCOHOLIC BEVERAGES	A	-1,714	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.00
44.00	DIAMOND CLUB FEES	B	-10,049	GENERAL	5.02	0	44.00
45.00	DAYCARE REVENUE	B	-1,747	ADMINISTRATION & ACCOUNTING	5.01	0	45.00
45.01	AMBULANCE RECEIPTS	B	-5,030	ADMINISTRATION & ACCOUNTING	5.01	0	45.01
45.05	MEDICAID TAX ASSESSMENT	A	-346,771	GENERAL	5.02	0	45.05
45.06	RETIREMENT OBLIGATION	A	-1,692	CAP REL COSTS-BLDG & FIXT	1.00	9	45.06
45.07	ACCRETION EXPENSE	A	-9,732	CAP REL COSTS-BLDG & FIXT	1.00	9	45.07
45.48	DONATIONS	A	-250	ADMINISTRATION & ACCOUNTING	5.01	0	45.48
45.49	PHYSICIAN RECRUITMENT	A	-98,078	ADMINISTRATION & ACCOUNTING	5.01	0	45.49
45.50	LAND RENTAL TO HILLSBORO AREA HEALTH	A	-41	ADMINISTRATION & ACCOUNTING	5.01	0	45.50
47.00	PATIENT TV DEPRECIATION	A	-3,827	CAP REL COSTS-MVBLE EQUIP	2.00	9	47.00
47.01	PHYSICAL THERAPY STAFF REVENUE	B	-9,750	PHYSICAL THERAPY	66.00	0	47.01
47.02	OCCUPATIONAL THERAPY STAFF REVENUE	B	-4,014	OCCUPATIONAL THERAPY	67.00	0	47.02
47.03	STUDENT EDUCATION REIMBURSEMENT	A	-20,720	ADMINISTRATION & ACCOUNTING	5.01	0	47.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,370,080				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2017 1:11 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	66.00	PHYSICAL THERAPY	RENT	41,235	41,235	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	WELLNESS BENEFIT	125,000	125,000	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			166,235	166,235	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	G	HILLSBORO HEALTH SERVICES	0.00	HILLSBORO HEALTH SERVICES	0.00	6.00
7.00	G	HILLSBORO HEALTH SERVICES	0.00	HILLSBORO HEALTH SERVICES	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1332	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-1 Date/Time Prepared: 11/22/2017 1:11 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	0			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HEALTH RELATED SERVICES		6.00
7.00	HEALTH RELATED SERVICES		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2017 1:11 pm

	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	60.00	LABORATORY	103,277	57,959	45,318	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	33,985	33,985	0	0	0	2.00
3.00	91.00	EMERGENCY	1,627,312	1,082,325	544,987	0	0	3.00
4.00	65.50	SLEEP LAB	21,300	21,300	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,785,874	1,195,569	590,305		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	65.50	SLEEP LAB	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	60.00	LABORATORY	0	0	0	57,959		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	33,985		2.00
3.00	91.00	EMERGENCY	0	0	0	1,082,325		3.00
4.00	65.50	SLEEP LAB	0	0	0	21,300		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,195,569		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	314,457	314,457				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	858,280		858,280			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,590,971	1,112	136	2,592,219		4.00
5.01	00592	ADMINISTRATION & ACCOUNTING	1,126,814	45,230	7,294	120,859	1,300,197	5.01
5.02	00591	GENERAL	602,894	45,230	98,632	64,327	811,083	5.02
5.03	00570	ADMITTING	175,270	3,218	921	55,726	235,135	5.03
5.04	00580	PATIENT ACCOUNTING	364,207	4,831	294	71,512	440,844	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	563,687	20,289	13,290	66,171	663,437	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	92,738	8,927	2,325	21,440	125,430	8.00
9.00	00900	HOUSEKEEPING	155,329	1,229	307	46,937	203,802	9.00
10.00	01000	DIETARY	212,963	13,237	4,696	45,118	276,014	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
13.01	01301	UR/QUALITY IMPROVEMENT	184,347	448	0	61,281	246,076	13.01
13.02	01302	NURSING ADMINISTRATION	253,861	8,690	35	85,560	348,146	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	40,578	3,792	757	13,050	58,177	14.02
15.00	01500	PHARMACY	416,857	2,395	31,724	0	450,976	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	287,695	8,223	445	66,441	362,804	16.00
17.00	01700	SOCIAL SERVICE	716	0	0	0	716	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,255,503	44,680	39,865	368,367	1,708,415	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	956,120	27,090	58,873	191,560	1,233,643	50.00
53.00	05300	ANESTHESIOLOGY	13,663	251	8,676	0	22,590	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	743,974	15,374	232,879	156,559	1,148,786	54.00
54.01	03040	ULTRA SOUND	207,007	926	405	0	208,338	54.01
56.00	05600	RADIOISOTOPE	462,752	4,375	260,770	26,966	754,863	56.00
60.00	06000	LABORATORY	1,160,409	8,288	29,119	182,257	1,380,073	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	155,789	3,834	4,573	47,595	211,791	65.00
65.50	06501	SLEEP LAB	122,311	1,173	790	17,624	141,898	65.50
66.00	06600	PHYSICAL THERAPY	1,031,698	18,007	24,001	322,771	1,396,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,032	0	331	42,830	171,193	67.00
69.00	06900	ELECTROCARDIOLOGY	25,788	0	5,475	0	31,263	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	91,982	0	0	0	91,982	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	467,376	0	0	0	467,376	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,529,239	23,608	31,523	275,932	1,860,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,593,307	314,457	858,136	2,350,883	16,351,827	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	1,326,299	0	0	241,336	1,567,635	192.02
192.03	19202	CARDIAC REHAB	0	0	144	0	144	192.03
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)	17,919,606	314,457	858,280	2,592,219	17,919,606	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	ADMINISTRATION & ACCOUNTING	Subtotal	GENERAL	ADMITTING	PATIENT ACCOUNTING	
			5.01	5A.01	5.02	5.03	5.04	
		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	00592	ADMINISTRATION & ACCOUNTING	1,300,197					5.01
5.02	00591	GENERAL	63,454	874,537	874,537			5.02
5.03	00570	ADMITTING	18,396	253,531	14,440	267,971		5.03
5.04	00580	PATIENT ACCOUNTING	34,489	475,333	27,073	0	502,406	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	51,903	715,340	40,742	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,813	135,243	7,703	0	0	8.00
9.00	00900	HOUSEKEEPING	15,944	219,746	12,516	0	0	9.00
10.00	01000	DIETARY	21,594	297,608	16,950	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
13.01	01301	UR/QUALITY IMPROVEMENT	19,252	265,328	15,112	0	0	13.01
13.02	01302	NURSING ADMINISTRATION	27,237	375,383	21,380	0	0	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	4,551	62,728	3,573	0	0	14.02
15.00	01500	PHARMACY	35,282	486,258	27,695	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,384	391,188	22,280	0	0	16.00
17.00	01700	SOCIAL SERVICE	56	772	44	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	133,656	1,842,071	104,915	20,129	37,737	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	96,513	1,330,156	75,759	24,769	46,436	50.00
53.00	05300	ANESTHESIOLOGY	1,767	24,357	1,387	3,294	6,175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,874	1,238,660	70,548	62,989	118,112	54.00
54.01	03040	ULTRA SOUND	16,299	224,637	12,794	11,197	20,993	54.01
56.00	05600	RADIOISOTOPE	59,056	813,919	46,357	18,672	35,005	56.00
60.00	06000	LABORATORY	107,969	1,488,042	84,751	38,341	71,881	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	16,569	228,360	13,006	2,229	4,178	65.00
65.50	06501	SLEEP LAB	11,101	152,999	8,714	4,846	9,085	65.50
66.00	06600	PHYSICAL THERAPY	109,252	1,505,729	85,759	21,895	41,048	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,393	184,586	10,513	1,419	2,661	67.00
69.00	06900	ELECTROCARDIOLOGY	2,446	33,709	1,920	3,707	6,950	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	7,196	99,178	5,649	7,867	14,748	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,565	503,941	28,702	13,257	24,855	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	145,533	2,005,835	114,246	33,360	62,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,177,544	16,229,174	874,528	267,971	502,406	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	122,642	1,690,277	0	0	0	192.02
192.03	19202	CARDIAC REHAB	11	155	9	0	0	192.03
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)	1,300,197	17,919,606	874,537	267,971	502,406	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		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	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	756,082				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,692	177,638			8.00
9.00	00900	HOUSEKEEPING	0	4,777	10,021	247,060		9.00
10.00	01000	DIETARY	0	51,443	4,276	0	370,277	10.00
11.00	01100	CAFETERIA	0	0	0	2,056	207,786	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
13.01	01301	UR/QUALITY IMPROVEMENT	0	1,742	0	3,265	0	13.01
13.02	01302	NURSING ADMINISTRATION	0	33,774	0	967	0	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	14,738	0	0	0	14.02
15.00	01500	PHARMACY	0	9,307	0	3,386	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,958	0	1,451	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	173,641	96,445	65,060	122,855	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	105,281	8,663	76,186	19,103	50.00
53.00	05300	ANESTHESIOLOGY	0	977	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,749	14,520	13,423	0	54.00
54.01	03040	ULTRA SOUND	0	3,599	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	17,001	0	484	0	56.00
60.00	06000	LABORATORY	0	32,211	0	9,433	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	14,901	0	3,386	0	65.00
65.50	06501	SLEEP LAB	0	4,560	2,720	3,265	0	65.50
66.00	06600	PHYSICAL THERAPY	0	69,983	14,924	15,600	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	91,748	26,069	49,098	20,533	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	756,082	177,638	247,060	370,277	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
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)	0	756,082	177,638	247,060	370,277	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	UR/QUALITY IMPROVEMENT	NURSING ADMINISTRATIO N	
			11.00	12.00	13.00	13.01	13.02	
		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	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	209,842					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0			13.00
13.01	01301	UR/QUALITY IMPROVEMENT	6,046	0	0	291,493		13.01
13.02	01302	NURSING ADMINISTRATION	6,598	0	0	0	438,102	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	3,517	0	0	0	0	14.02
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,908	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,634	0	0	291,493	180,963	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,885	0	0	0	99,593	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,000	0	0	0	0	54.00
54.01	03040	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	2,575	0	0	0	0	56.00
60.00	06000	LABORATORY	23,311	0	0	0	1,021	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	5,540	0	0	0	2,041	65.00
65.50	06501	SLEEP LAB	2,023	0	0	0	1,963	65.50
66.00	06600	PHYSICAL THERAPY	23,770	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,379	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	31,656	0	0	0	152,521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	209,842	0	0	291,493	438,102	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
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)	209,842	0	0	291,493	438,102	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			14.00	14.01	14.02	15.00	16.00	
		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	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	UR/QUALITY IMPROVEMENT						13.01
13.02	01302	NURSING ADMINISTRATION						13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0					14.00
14.01	01401	PURCHASING	0	0				14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	84,556			14.02
15.00	01500	PHARMACY	0	0	266	526,912		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	363	0	459,148	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	5,352	3,528	165,512	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	24,869	1,453	81,657	50.00
53.00	05300	ANESTHESIOLOGY	0	0	699	770	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,162	16,462	51,139	54.00
54.01	03040	ULTRA SOUND	0	0	1,522	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	1,059	27,673	0	56.00
60.00	06000	LABORATORY	0	0	30,487	0	51,139	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	9,898	65.00
65.50	06501	SLEEP LAB	0	0	48	0	8,523	65.50
66.00	06600	PHYSICAL THERAPY	0	0	422	1	8,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	223	0	5,224	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	38	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	8,469	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	474,756	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	5,577	2,269	77,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	84,556	526,912	459,148	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
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)	0	0	84,556	526,912	459,148	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES A	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS A	
			17.00	19.00	20.00	21.00	22.00	
		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	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	UR/QUALITY IMPROVEMENT						13.01
13.02	01302	NURSING ADMINISTRATION						13.02
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
14.01	01401	PURCHASING						14.01
14.02	01402	CENTRAL SERVICES & SUPPLY						14.02
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	816					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00	02000	NURSING SCHOOL	0		0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0			0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0				0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	816	0	0	0	0	30.00
		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
54.01	03040	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.50	06501	SLEEP LAB	0	0	0	0	0	65.50
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	816	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	816	0	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	UR/QUALITY IMPROVEMENT						13.01
13.02	01302	NURSING ADMINISTRATION						13.02
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
14.01	01401	PURCHASING						14.01
14.02	01402	CENTRAL SERVICES & SUPPLY						14.02
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A						22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,162,151	0	3,162,151		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,913,810	0	1,913,810		50.00
53.00	05300	ANESTHESIOLOGY	0	37,659	0	37,659		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,668,764	0	1,668,764		54.00
54.01	03040	ULTRA SOUND	0	274,742	0	274,742		54.01
56.00	05600	RADIOISOTOPE	0	962,745	0	962,745		56.00
60.00	06000	LABORATORY	0	1,830,617	0	1,830,617		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	283,539	0	283,539		65.00
65.50	06501	SLEEP LAB	0	198,746	0	198,746		65.50
66.00	06600	PHYSICAL THERAPY	0	1,787,379	0	1,787,379		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	208,005	0	208,005		67.00
69.00	06900	ELECTROCARDIOLOGY	0	46,324	0	46,324		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	135,911	0	135,911		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,045,511	0	1,045,511		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	2,673,262	0	2,673,262		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0		99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	16,229,165	0	16,229,165		118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	1,690,277	0	1,690,277		192.02
192.03	19202	CARDIAC REHAB	0	164	0	164		192.03
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	17,919,606	0	17,919,606		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/22/2017 1:11 pm

		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	1,112	136	1,248	1,248	4.00
5.01	00592	ADMINISTRATION & ACCOUNTING	0	45,230	7,294	52,524	58	5.01
5.02	00591	GENERAL	0	45,230	98,632	143,862	31	5.02
5.03	00570	ADMITTING	0	3,218	921	4,139	27	5.03
5.04	00580	PATIENT ACCOUNTING	0	4,831	294	5,125	34	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	20,289	13,290	33,579	32	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,927	2,325	11,252	10	8.00
9.00	00900	HOUSEKEEPING	0	1,229	307	1,536	23	9.00
10.00	01000	DIETARY	0	13,237	4,696	17,933	22	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
13.01	01301	UR/QUALITY IMPROVEMENT	0	448	0	448	29	13.01
13.02	01302	NURSING ADMINISTRATION	0	8,690	35	8,725	41	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	3,792	757	4,549	6	14.02
15.00	01500	PHARMACY	0	2,395	31,724	34,119	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,223	445	8,668	32	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	44,680	39,865	84,545	179	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,090	58,873	85,963	92	50.00
53.00	05300	ANESTHESIOLOGY	0	251	8,676	8,927	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,374	232,879	248,253	75	54.00
54.01	03040	ULTRA SOUND	0	926	405	1,331	0	54.01
56.00	05600	RADIOISOTOPE	0	4,375	260,770	265,145	13	56.00
60.00	06000	LABORATORY	0	8,288	29,119	37,407	88	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,834	4,573	8,407	23	65.00
65.50	06501	SLEEP LAB	0	1,173	790	1,963	8	65.50
66.00	06600	PHYSICAL THERAPY	0	18,007	24,001	42,008	155	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	331	331	21	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,475	5,475	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	23,608	31,523	55,131	133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	314,457	858,136	1,172,593	1,132	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	116	192.02
192.03	19202	CARDIAC REHAB	0	0	144	144	0	192.03
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	314,457	858,280	1,172,737	1,248	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	ADMINISTRATION & ACCOUNTING	GENERAL	ADMITTING	PATIENT ACCOUNTING	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
		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	00592	ADMINISTRATION & ACCOUNTING	52,582					5.01
5.02	00591	GENERAL	2,566	146,459				5.02
5.03	00570	ADMITTING	744	2,418	7,328			5.03
5.04	00580	PATIENT ACCOUNTING	1,395	4,534	0	11,088		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,099	6,823	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	397	1,290	0	0	0	8.00
9.00	00900	HOUSEKEEPING	645	2,096	0	0	0	9.00
10.00	01000	DIETARY	873	2,839	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
13.01	01301	UR/QUALITY IMPROVEMENT	779	2,531	0	0	0	13.01
13.02	01302	NURSING ADMINISTRATION	1,102	3,580	0	0	0	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	184	598	0	0	0	14.02
15.00	01500	PHARMACY	1,427	4,638	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,148	3,731	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	2	7	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,405	17,570	550	834	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,903	12,687	677	1,027	0	50.00
53.00	05300	ANESTHESIOLOGY	71	232	90	137	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,635	11,814	1,726	2,592	0	54.00
54.01	03040	ULTRA SOUND	659	2,143	306	464	0	54.01
56.00	05600	RADIOISOTOPE	2,388	7,763	510	774	0	56.00
60.00	06000	LABORATORY	4,367	14,193	1,048	1,589	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	670	2,178	61	92	0	65.00
65.50	06501	SLEEP LAB	449	1,459	132	201	0	65.50
66.00	06600	PHYSICAL THERAPY	4,418	14,362	599	907	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	542	1,761	39	59	0	67.00
69.00	06900	ELECTROCARDIOLOGY	99	322	101	154	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	291	946	215	326	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,479	4,807	362	549	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,885	19,136	912	1,383	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,622	146,458	7,328	11,088	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	4,960	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	1	0	0	0	192.03
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)	52,582	146,459	7,328	11,088	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	42,533					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,952	14,901				8.00
9.00	00900	HOUSEKEEPING	269	841	5,410			9.00
10.00	01000	DIETARY	2,894	359	0	24,920		10.00
11.00	01100	CAFETERIA	0	0	45	13,984	14,029	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
13.01	01301	UR/QUALITY IMPROVEMENT	98	0	71	0	404	13.01
13.02	01302	NURSING ADMINISTRATION	1,900	0	21	0	441	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	829	0	0	0	235	14.02
15.00	01500	PHARMACY	524	0	74	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,798	0	32	0	796	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,767	8,089	1,425	8,268	3,455	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,923	727	1,668	1,286	1,329	50.00
53.00	05300	ANESTHESIOLOGY	55	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,361	1,218	294	0	1,203	54.00
54.01	03040	ULTRA SOUND	202	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	956	0	11	0	172	56.00
60.00	06000	LABORATORY	1,812	0	207	0	1,558	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	838	0	74	0	370	65.00
65.50	06501	SLEEP LAB	257	228	71	0	135	65.50
66.00	06600	PHYSICAL THERAPY	3,937	1,252	342	0	1,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	226	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,161	2,187	1,075	1,382	2,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,533	14,901	5,410	24,920	14,029	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
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)	42,533	14,901	5,410	24,920	14,029	202.00

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		Cost Center Description	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	UR/QUALITY IMPROVEMENT	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			12.00	13.00	13.01	13.02	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	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	0				13.00
13.01	01301	UR/QUALITY IMPROVEMENT	0	0	4,360			13.01
13.02	01302	NURSING ADMINISTRATION	0	0	0	15,810		13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.02
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,360	6,530	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,594	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
54.01	03040	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	37	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	74	0	65.00
65.50	06501	SLEEP LAB	0	0	0	71	0	65.50
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	5,504	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	4,360	15,810	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
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)	0	0	4,360	15,810	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			14.01	14.02	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	UR/QUALITY IMPROVEMENT						13.01
13.02	01302	NURSING ADMINISTRATION						13.02
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
14.01	01401	PURCHASING	0					14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	6,401				14.02
15.00	01500	PHARMACY	0	20	40,802			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27	0	16,232		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	9	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	405	273	5,850	9	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,883	112	2,887	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53	60	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	391	1,275	1,808	0	54.00
54.01	03040	ULTRA SOUND	0	115	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	80	2,143	0	0	56.00
60.00	06000	LABORATORY	0	2,308	0	1,808	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	350	0	65.00
65.50	06501	SLEEP LAB	0	4	0	301	0	65.50
66.00	06600	PHYSICAL THERAPY	0	32	0	292	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17	0	185	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	3	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	641	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	36,763	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	422	176	2,751	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	6,401	40,802	16,232	9	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
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)	0	6,401	40,802	16,232	9	202.00

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		Cost Center Description	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES A	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS A	PARAMED ED PRGM	
			19.00	20.00	21.00	22.00	23.00	
		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	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	UR/QUALITY IMPROVEMENT						13.01
13.02	01302	NURSING ADMINISTRATION						13.02
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
14.01	01401	PURCHASING						14.01
14.02	01402	CENTRAL SERVICES & SUPPLY						14.02
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
20.00	02000	NURSING SCHOOL		0				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A			0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A				0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS						30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM						50.00
53.00	05300	ANESTHESIOLOGY						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC						54.00
54.01	03040	ULTRA SOUND						54.01
56.00	05600	RADIOISOTOPE						56.00
60.00	06000	LABORATORY						60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65.00	06500	RESPIRATORY THERAPY						65.00
65.50	06501	SLEEP LAB						65.50
66.00	06600	PHYSICAL THERAPY						66.00
67.00	06700	OCCUPATIONAL THERAPY						67.00
69.00	06900	ELECTROCARDIOLOGY						69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT						71.00
73.00	07300	DRUGS CHARGED TO PATIENTS						73.00
76.97	07697	CARDIAC REHABILITATION						76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY						76.98
76.99	07699	LITHOTRIPSY						76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF						99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY						99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING						192.02
192.03	19202	CARDIAC REHAB						192.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00592	ADMINISTRATION & ACCOUNTING					5.01
5.02	00591	GENERAL					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	PATIENT ACCOUNTING					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
13.01	01301	UR/QUALITY IMPROVEMENT					13.01
13.02	01302	NURSING ADMINISTRATION					13.02
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
14.01	01401	PURCHASING					14.01
14.02	01402	CENTRAL SERVICES & SUPPLY					14.02
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	157,514	0	157,514		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	123,758	0	123,758		50.00
53.00	05300	ANESTHESIOLOGY	9,625	0	9,625		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	277,645	0	277,645		54.00
54.01	03040	ULTRA SOUND	5,220	0	5,220		54.01
56.00	05600	RADIOISOTOPE	279,955	0	279,955		56.00
60.00	06000	LABORATORY	66,422	0	66,422		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	13,137	0	13,137		65.00
65.50	06501	SLEEP LAB	5,279	0	5,279		65.50
66.00	06600	PHYSICAL THERAPY	69,893	0	69,893		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,181	0	3,181		67.00
69.00	06900	ELECTROCARDIOLOGY	6,154	0	6,154		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,419	0	2,419		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,960	0	43,960		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	103,354	0	103,354		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,167,516	0	1,167,516		118.00
		NONREIMBURSABLE COST CENTERS					
192.02	19201	ASSISTED LIVING	5,076	0	5,076		192.02
192.03	19202	CARDIAC REHAB	145	0	145		192.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,172,737	0	1,172,737		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATION & ACCOUNTING (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,504,600					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		829,437				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	26,545	131	7,414,859			4.00
5.01	00592	ADMINISTRATION & ACCOUNTING	1,079,420	7,049	345,708	-1,300,197	16,619,409	5.01
5.02	00591	GENERAL	1,079,420	95,317	184,002	0	811,083	5.02
5.03	00570	ADMITTING	76,800	890	159,401	0	235,135	5.03
5.04	00580	PATIENT ACCOUNTING	115,300	284	204,555	0	440,844	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	484,209	12,843	189,277	0	663,437	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	213,033	2,247	61,329	0	125,430	8.00
9.00	00900	HOUSEKEEPING	29,333	297	134,259	0	203,802	9.00
10.00	01000	DIETARY	315,900	4,538	129,058	0	276,014	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
13.01	01301	UR/QUALITY IMPROVEMENT	10,700	0	175,289	0	246,076	13.01
13.02	01302	NURSING ADMINISTRATION	207,400	34	244,738	0	348,146	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	90,500	732	37,329	0	58,177	14.02
15.00	01500	PHARMACY	57,149	30,658	0	0	450,976	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	196,244	430	190,051	0	362,804	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	716	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,066,300	38,525	1,053,690	0	1,708,415	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	646,500	56,895	547,943	0	1,233,643	50.00
53.00	05300	ANESTHESIOLOGY	6,000	8,384	0	0	22,590	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	366,900	225,053	447,827	0	1,148,786	54.00
54.01	03040	ULTRA SOUND	22,100	391	0	0	208,338	54.01
56.00	05600	RADIOISOTOPE	104,400	252,009	77,134	0	754,863	56.00
60.00	06000	LABORATORY	197,800	28,140	521,332	0	1,380,073	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	91,500	4,419	136,142	0	211,791	65.00
65.50	06501	SLEEP LAB	28,000	763	50,411	0	141,898	65.50
66.00	06600	PHYSICAL THERAPY	429,747	23,194	923,264	0	1,396,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	320	122,511	0	171,193	67.00
69.00	06900	ELECTROCARDIOLOGY	0	5,291	0	0	31,263	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	91,982	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	467,376	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	563,400	30,464	789,284	0	1,860,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,504,600	829,298	6,724,534	-1,300,197	15,051,630	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	690,325	0	1,567,635	192.02
192.03	19202	CARDIAC REHAB	0	139	0	0	144	192.03
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)	314,457	858,280	2,592,219		1,300,197	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.041902	1.034774	0.349598		0.078234	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,248		52,582	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:11 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATION & ACCOUNTING (ACCUM. COST)	
		1.00	2.00	4.00	5A.01	5.01	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000168		0.003164	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	Reconciliation	GENERAL (ACCUM. COST)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5A.02	5.02	5.03	5.04	6.00	
		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	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL	-874,537	15,354,792				5.02
5.03	00570	ADMITTING	0	253,531	39,385,089			5.03
5.04	00580	PATIENT ACCOUNTING	0	475,333	0	39,385,089		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	715,340	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	135,243	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	219,746	0	0	0	9.00
10.00	01000	DIETARY	0	297,608	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
13.01	01301	UR/QUALITY IMPROVEMENT	0	265,328	0	0	0	13.01
13.02	01302	NURSING ADMINISTRATION	0	375,383	0	0	0	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	62,728	0	0	0	14.02
15.00	01500	PHARMACY	0	486,258	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	391,188	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	772	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,842,071	2,958,336	2,958,336	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,330,156	3,640,359	3,640,359	0	50.00
53.00	05300	ANESTHESIOLOGY	0	24,357	484,087	484,087	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,238,660	9,258,459	9,258,459	0	54.00
54.01	03040	ULTRA SOUND	0	224,637	1,645,721	1,645,721	0	54.01
56.00	05600	RADIOISOTOPE	0	813,919	2,744,207	2,744,207	0	56.00
60.00	06000	LABORATORY	0	1,488,042	5,635,112	5,635,112	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	228,360	327,537	327,537	0	65.00
65.50	06501	SLEEP LAB	0	152,999	712,231	712,231	0	65.50
66.00	06600	PHYSICAL THERAPY	0	1,505,729	3,217,908	3,217,908	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	184,586	208,625	208,625	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	33,709	544,866	544,866	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	99,178	1,156,185	1,156,185	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	503,941	1,948,480	1,948,480	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	2,005,835	4,902,976	4,902,976	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-874,537	15,354,637	39,385,089	39,385,089	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	-1,690,277	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	155	0	0	0	192.03
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)		874,537	267,971	502,406	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.056955	0.006804	0.012756	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		146,459	7,328	11,088	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.009538	0.000186	0.000282	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	4,642,906					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	213,033	148,643				8.00
9.00	00900	HOUSEKEEPING	29,333	8,385	2,043			9.00
10.00	01000	DIETARY	315,900	3,578	0	24,868		10.00
11.00	01100	CAFETERIA	0	0	17	13,955	9,128	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
13.01	01301	UR/QUALITY IMPROVEMENT	10,700	0	27	0	263	13.01
13.02	01302	NURSING ADMINISTRATION	207,400	0	8	0	287	13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	90,500	0	0	0	153	14.02
15.00	01500	PHARMACY	57,149	0	28	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	196,244	0	12	0	518	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,066,300	80,703	538	8,251	2,246	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	646,500	7,249	630	1,283	865	50.00
53.00	05300	ANESTHESIOLOGY	6,000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	366,900	12,150	111	0	783	54.00
54.01	03040	ULTRA SOUND	22,100	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	104,400	0	4	0	112	56.00
60.00	06000	LABORATORY	197,800	0	78	0	1,014	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	91,500	0	28	0	241	65.00
65.50	06501	SLEEP LAB	28,000	2,276	27	0	88	65.50
66.00	06600	PHYSICAL THERAPY	429,747	12,488	129	0	1,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	147	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	563,400	21,814	406	1,379	1,377	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,642,906	148,643	2,043	24,868	9,128	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
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)	756,082	177,638	247,060	370,277	209,842	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.162847	1.195065	120.930005	14.889698	22.988826	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,533	14,901	5,410	24,920	14,029	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009161	0.100247	2.648067	1.002091	1.536919	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	UR/QUALITY IMPROVEMENT (DIRECT NRSING HRS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			12.00	13.00	13.01	13.02	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	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	0				13.00
13.01	01301	UR/QUALITY IMPROVEMENT	0	0	3,688			13.01
13.02	01302	NURSING ADMINISTRATION	0	0	0	55,805		13.02
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.02
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,688	23,051	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	12,686	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
54.01	03040	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	130	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	260	0	65.00
65.50	06501	SLEEP LAB	0	0	0	250	0	65.50
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	19,428	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	3,688	55,805	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	291,493	438,102	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	79.038232	7.850587	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	4,360	15,810	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	1.182213	0.283308	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	PURCHASING (COSTED REQ UIS.)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS.)	PHARMACY (COSTED REQ UIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			14.01	14.02	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	UR/QUALITY IMPROVEMENT						13.01
13.02	01302	NURSING ADMINISTRATION						13.02
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
14.01	01401	PURCHASING	0					14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	885,460				14.02
15.00	01500	PHARMACY	0	2,783	518,721			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,803	0	1,670		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	56,047	3,473	602	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	260,427	1,430	297	0	50.00
53.00	05300	ANESTHESIOLOGY	0	7,316	758	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,052	16,206	186	0	54.00
54.01	03040	ULTRA SOUND	0	15,938	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	11,085	27,243	0	0	56.00
60.00	06000	LABORATORY	0	319,280	0	186	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	36	0	65.00
65.50	06501	SLEEP LAB	0	502	0	31	0	65.50
66.00	06600	PHYSICAL THERAPY	0	4,414	1	30	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,336	0	19	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	393	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	88,682	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	467,376	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	58,402	2,234	283	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	885,460	518,721	1,670	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	84,556	526,912	459,148	816	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.095494	1.015791	274.938922	8.160000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	6,401	40,802	16,232	9	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.007229	0.078659	9.719760	0.090000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES A (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS A (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
			19.00	20.00	21.00	22.00	23.00	
		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	00592	ADMINISTRATION & ACCOUNTING						5.01
5.02	00591	GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
13.01	01301	UR/QUALITY IMPROVEMENT						13.01
13.02	01302	NURSING ADMINISTRATION						13.02
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
14.01	01401	PURCHASING						14.01
14.02	01402	CENTRAL SERVICES & SUPPLY						14.02
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
20.00	02000	NURSING SCHOOL		0				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A			0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A				0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
		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
54.01	03040	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.50	06501	SLEEP LAB	0	0	0	0	0	65.50
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	0	0	0	0	0	192.02
192.03	19202	CARDIAC REHAB	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:11 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES A (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS A (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
			19.00	20.00	21.00	22.00	23.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:11 pm

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	3,162,151		3,162,151	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,913,810		1,913,810	0	0	50.00
53.00	05300	ANESTHESIOLOGY	37,659		37,659	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,668,764		1,668,764	0	0	54.00
54.01	03040	ULTRA SOUND	274,742		274,742	0	0	54.01
56.00	05600	RADIOISOTOPE	962,745		962,745	0	0	56.00
60.00	06000	LABORATORY	1,830,617		1,830,617	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	283,539	0	283,539	0	0	65.00
65.50	06501	SLEEP LAB	198,746	0	198,746	0	0	65.50
66.00	06600	PHYSICAL THERAPY	1,787,379	0	1,787,379	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,005	0	208,005	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	46,324		46,324	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	135,911		135,911	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,045,511		1,045,511	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,673,262		2,673,262	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	548,509		548,509		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00		Subtotal (see instructions)	16,777,674	0	16,777,674	0	0	200.00
201.00		Less Observation Beds	548,509		548,509		0	201.00
202.00		Total (see instructions)	16,229,165	0	16,229,165	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:11 pm

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	1,924,132		1,924,132			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,653	3,628,706	3,640,359	0.525720	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,018	482,069	484,087	0.077794	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	276,178	8,982,281	9,258,459	0.180242	0.000000	54.00
54.01	03040	ULTRA SOUND	91,316	1,554,405	1,645,721	0.166943	0.000000	54.01
56.00	05600	RADIOISOTOPE	44,312	2,699,895	2,744,207	0.350828	0.000000	56.00
60.00	06000	LABORATORY	511,237	5,123,875	5,635,112	0.324859	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	178,061	149,476	327,537	0.865670	0.000000	65.00
65.50	06501	SLEEP LAB	998	711,233	712,231	0.279047	0.000000	65.50
66.00	06600	PHYSICAL THERAPY	295,006	2,922,902	3,217,908	0.555448	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	81,819	126,806	208,625	0.997028	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	15,514	529,352	544,866	0.085019	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	397,965	758,220	1,156,185	0.117551	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	494,500	1,453,980	1,948,480	0.536578	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,400	4,897,576	4,902,976	0.545233	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	113,597	920,607	1,034,204	0.530368	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	4,443,706	34,941,383	39,385,089			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,443,706	34,941,383	39,385,089			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:11 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		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
54.01	03040	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.50	06501	SLEEP LAB	0.000000	65.50
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY		99.40
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: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:11 pm

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	3,162,151		3,162,151	0	3,162,151	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,913,810		1,913,810	0	1,913,810	50.00
53.00	05300	ANESTHESIOLOGY	37,659		37,659	0	37,659	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,668,764		1,668,764	0	1,668,764	54.00
54.01	03040	ULTRA SOUND	274,742		274,742	0	274,742	54.01
56.00	05600	RADIOISOTOPE	962,745		962,745	0	962,745	56.00
60.00	06000	LABORATORY	1,830,617		1,830,617	0	1,830,617	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	283,539	0	283,539	0	283,539	65.00
65.50	06501	SLEEP LAB	198,746	0	198,746	0	198,746	65.50
66.00	06600	PHYSICAL THERAPY	1,787,379	0	1,787,379	0	1,787,379	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,005	0	208,005	0	208,005	67.00
69.00	06900	ELECTROCARDIOLOGY	46,324		46,324	0	46,324	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	135,911		135,911	0	135,911	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,045,511		1,045,511	0	1,045,511	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,673,262		2,673,262	0	2,673,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	548,509		548,509		548,509	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00		Subtotal (see instructions)	16,777,674	0	16,777,674	0	16,777,674	200.00
201.00		Less Observation Beds	548,509		548,509		548,509	201.00
202.00		Total (see instructions)	16,229,165	0	16,229,165	0	16,229,165	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:11 pm

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	1,924,132		1,924,132			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,653	3,628,706	3,640,359	0.525720	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,018	482,069	484,087	0.077794	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	276,178	8,982,281	9,258,459	0.180242	0.000000	54.00
54.01	03040	ULTRA SOUND	91,316	1,554,405	1,645,721	0.166943	0.000000	54.01
56.00	05600	RADIOISOTOPE	44,312	2,699,895	2,744,207	0.350828	0.000000	56.00
60.00	06000	LABORATORY	511,237	5,123,875	5,635,112	0.324859	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	178,061	149,476	327,537	0.865670	0.000000	65.00
65.50	06501	SLEEP LAB	998	711,233	712,231	0.279047	0.000000	65.50
66.00	06600	PHYSICAL THERAPY	295,006	2,922,902	3,217,908	0.555448	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	81,819	126,806	208,625	0.997028	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	15,514	529,352	544,866	0.085019	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	397,965	758,220	1,156,185	0.117551	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	494,500	1,453,980	1,948,480	0.536578	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,400	4,897,576	4,902,976	0.545233	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	113,597	920,607	1,034,204	0.530368	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	4,443,706	34,941,383	39,385,089			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,443,706	34,941,383	39,385,089			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		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
54.01	03040	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.50	06501	SLEEP LAB	0.000000	65.50
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY		99.40
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: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/22/2017 1:11 pm

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	123,758	3,640,359	0.033996	11,428	389	50.00
53.00	05300	ANESTHESIOLOGY	9,625	484,087	0.019883	2,018	40	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	277,645	9,258,459	0.029988	132,397	3,970	54.00
54.01	03040	ULTRA SOUND	5,220	1,645,721	0.003172	58,492	186	54.01
56.00	05600	RADIOISOTOPE	279,955	2,744,207	0.102017	21,640	2,208	56.00
60.00	06000	LABORATORY	66,422	5,635,112	0.011787	260,797	3,074	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	13,137	327,537	0.040108	44,469	1,784	65.00
65.50	06501	SLEEP LAB	5,279	712,231	0.007412	0	0	65.50
66.00	06600	PHYSICAL THERAPY	69,893	3,217,908	0.021720	32,027	696	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,181	208,625	0.015247	6,938	106	67.00
69.00	06900	ELECTROCARDIOLOGY	6,154	544,866	0.011295	8,816	100	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,419	1,156,185	0.002092	185,271	388	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,960	1,948,480	0.022561	198,542	4,479	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	103,354	4,902,976	0.021080	4,289	90	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	27,322	1,034,204	0.026418	0	0	92.00
200.00		Total (lines 50-199)	1,037,324	37,460,957		967,124	17,510	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/22/2017 1:11 pm

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
54.01	03040	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.50	06501	SLEEP LAB	0	0	0	0	0	65.50
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/22/2017 1:11 pm

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	3,640,359	0.000000	0.000000	11,428	50.00
53.00	05300	ANESTHESIOLOGY	0	484,087	0.000000	0.000000	2,018	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,258,459	0.000000	0.000000	132,397	54.00
54.01	03040	ULTRA SOUND	0	1,645,721	0.000000	0.000000	58,492	54.01
56.00	05600	RADIOISOTOPE	0	2,744,207	0.000000	0.000000	21,640	56.00
60.00	06000	LABORATORY	0	5,635,112	0.000000	0.000000	260,797	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	327,537	0.000000	0.000000	44,469	65.00
65.50	06501	SLEEP LAB	0	712,231	0.000000	0.000000	0	65.50
66.00	06600	PHYSICAL THERAPY	0	3,217,908	0.000000	0.000000	32,027	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	208,625	0.000000	0.000000	6,938	67.00
69.00	06900	ELECTROCARDIOLOGY	0	544,866	0.000000	0.000000	8,816	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,156,185	0.000000	0.000000	185,271	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,948,480	0.000000	0.000000	198,542	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	4,902,976	0.000000	0.000000	4,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,034,204	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	37,460,957			967,124	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/22/2017 1:11 pm

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
54.01	03040	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
65.50	06501	SLEEP LAB	0	0	0		65.50
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/22/2017 1:11 pm

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	0.525720	0	1,756,076	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.077794	0	208,322	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180242	0	3,464,611	0	0	54.00
54.01	03040	ULTRA SOUND	0.166943	0	644,454	0	0	54.01
56.00	05600	RADIOISOTOPE	0.350828	0	1,023,983	0	0	56.00
60.00	06000	LABORATORY	0.324859	0	2,188,499	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.865670	0	106,379	0	0	65.00
65.50	06501	SLEEP LAB	0.279047	0	220,770	0	0	65.50
66.00	06600	PHYSICAL THERAPY	0.555448	0	951,164	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.997028	0	54,363	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.085019	0	243,171	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.117551	0	426,045	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.536578	0	1,015,163	718	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.545233	0	1,968,500	89	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.530368	0	316,866	0	0	92.00
200.00		Subtotal (see instructions)		0	14,588,366	807	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	14,588,366	807	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/22/2017 1:11 pm

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	923,204	0		50.00
53.00	05300	ANESTHESIOLOGY	16,206	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	624,468	0		54.00
54.01	03040	ULTRA SOUND	107,587	0		54.01
56.00	05600	RADIOISOTOPE	359,242	0		56.00
60.00	06000	LABORATORY	710,954	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	92,089	0		65.00
65.50	06501	SLEEP LAB	61,605	0		65.50
66.00	06600	PHYSICAL THERAPY	528,322	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	54,201	0		67.00
69.00	06900	ELECTROCARDIOLOGY	20,674	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	50,082	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	544,714	385		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,073,291	49		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	168,056	0		92.00
200.00		Subtotal (see instructions)	5,334,695	434		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,334,695	434		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1332 | Component CCN: 14-Z332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/22/2017 1:11 pm

Title XVIII | Swing Beds - SNF | 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	0.525720	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.077794	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180242	0	0	0	0	54.00
54.01	03040	ULTRA SOUND	0.166943	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.350828	0	0	0	0	56.00
60.00	06000	LABORATORY	0.324859	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.865670	0	0	0	0	65.00
65.50	06501	SLEEP LAB	0.279047	0	0	0	0	65.50
66.00	06600	PHYSICAL THERAPY	0.555448	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.997028	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.085019	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.117551	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.536578	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.545233	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.530368	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: 14-1332 | Component CCN: 14-Z332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/22/2017 1:11 pm

Title XVIII | Swing Beds - SNF | 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	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03040	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.50	06501	SLEEP LAB	0	0	65.50
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 1:11 pm

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)	2,404	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,302	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)	885	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	563	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)	539	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)	651	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)	562	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)	514	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	130.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	135.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,162,151	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)	1,449,538	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,712,613	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)	1,712,613	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,315.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	856,306	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)	856,306	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 1:11 pm

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						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)	326,710	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,183,016	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)	739,238	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	676,100	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,415,338	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)	417	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,315.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	548,509	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 1:11 pm

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	157,514	3,162,151	0.049812	548,509	27,322	90.00
91.00	Nursing School cost	0	3,162,151	0.000000	548,509	0	91.00
92.00	Allied health cost	0	3,162,151	0.000000	548,509	0	92.00
93.00	All other Medical Education	0	3,162,151	0.000000	548,509	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 1:11 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,404	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,302	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)	885	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,102	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)	36	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	130.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	130.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,162,151	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)	1,449,538	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,712,613	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)	1,712,613	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,315.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	47,353	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)	47,353	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 1:11 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	47,353	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	417	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,315.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	548,509	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 1:11 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	157,514	3,162,151	0.049812	548,509	27,322	90.00
91.00	Nursing School cost	0	3,162,151	0.000000	548,509	0	91.00
92.00	Allied health cost	0	3,162,151	0.000000	548,509	0	92.00
93.00	All other Medical Education	0	3,162,151	0.000000	548,509	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/22/2017 1:11 pm

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		785,501		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.525720	11,428	6,008	50.00
53.00	05300	ANESTHESIOLOGY	0.077794	2,018	157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180242	132,397	23,864	54.00
54.01	03040	ULTRA SOUND	0.166943	58,492	9,765	54.01
56.00	05600	RADIOISOTOPE	0.350828	21,640	7,592	56.00
60.00	06000	LABORATORY	0.324859	260,797	84,722	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.865670	44,469	38,495	65.00
65.50	06501	SLEEP LAB	0.279047	0	0	65.50
66.00	06600	PHYSICAL THERAPY	0.555448	32,027	17,789	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.997028	6,938	6,917	67.00
69.00	06900	ELECTROCARDIOLOGY	0.085019	8,816	750	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.117551	185,271	21,779	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.536578	198,542	106,533	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.545233	4,289	2,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.530368	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		967,124	326,710	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)		967,124		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3

Component CCN: 14-Z332 | Date/Time Prepared: 11/22/2017 1:11 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.525720	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.077794	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180242	76,081	13,713	54.00
54.01	03040	ULTRA SOUND	0.166943	18,772	3,134	54.01
56.00	05600	RADIOISOTOPE	0.350828	11,806	4,142	56.00
60.00	06000	LABORATORY	0.324859	180,534	58,648	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.865670	19,464	16,849	65.00
65.50	06501	SLEEP LAB	0.279047	998	278	65.50
66.00	06600	PHYSICAL THERAPY	0.555448	246,271	136,791	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.997028	72,042	71,828	67.00
69.00	06900	ELECTROCARDIOLOGY	0.085019	2,108	179	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.117551	129,669	15,243	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.536578	224,305	120,357	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.545233	1,019	556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.530368	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		983,069	441,718	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)		983,069		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1332	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/22/2017 1:11 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,335,129	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)	5,335,129	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)	5,388,480	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)	55,430	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,496,451	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)	2,836,599	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)	2,836,599	30.00
31.00	Primary payer payments	451	31.00
32.00	Subtotal (line 30 minus line 31)	2,836,148	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)	328,674	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	213,638	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	328,674	36.00
37.00	Subtotal (see instructions)	3,049,786	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)	3,049,786	40.00
40.01	Sequestration adjustment (see instructions)	60,996	40.01
41.00	Interim payments	3,001,209	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-12,419	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: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/22/2017 1:11 pm

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		928,213		2,825,046	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	02/02/2017	143,215	3.01
3.02			0	06/29/2017	32,948	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	02/02/2017	37,919		0	3.50
3.51		06/29/2017	8,823		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)		-46,742		176,163	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)		881,471		3,001,209	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		99,208		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		12,419	6.02
7.00	Total Medicare program liability (see instructions)		980,679		2,988,790	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1332 | Component CCN: 14-Z332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2017 1:11 pm

Title XVIII | Swing Beds - SNF | 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		1,605,400		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	02/02/2017	7,453		0	3.50
3.51		06/29/2017	3,043		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)		-10,496		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,594,904		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		202,107		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,797,011		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1332	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/22/2017 1:11 pm
	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	301	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	651	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	65	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	885	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	39,385,089	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	694,962	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)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	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)	1	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1332 Component CCN: 14-Z332	Period: From 07/01/2016 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 11/22/2017 1:11 pm
	Title XVIII	Swing Beds - SNF	Cost

		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)	1,429,491	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)	446,135	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	1,076	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)	1,875,626	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,875,626	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)	1,875,626	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	41,941	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)	1,833,685	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)	1,833,685	0	19.00
19.01	Sequestration adjustment (see instructions)	36,674	0	19.01
20.00	Interim payments	1,594,904	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)	202,107	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: 14-1332	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/22/2017 1:11 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,183,016	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)	1,183,016	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,194,846	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)	1,194,846	19.00
20.00	Deductibles (exclude professional component)	210,354	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	984,492	22.00
23.00	Coinsurance	2,576	23.00
24.00	Subtotal (line 22 minus line 23)	981,916	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,887	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,777	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	28,887	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,000,693	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)	1,000,693	30.00
30.01	Sequestration adjustment (see instructions)	20,014	30.01
31.00	Interim payments	881,471	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)	99,208	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1332	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2017 1:11 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	47,353		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	47,353	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	47,353	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	47,353	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	47,353	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	47,353	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	47,353	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	47,353	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	47,353	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	47,353	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	47,353	0	40.00
41.00	Interim payments	47,480	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-127	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/22/2017 1:11 pm

		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	-258,118	0	0	0	1.00
2.00	Temporary investments	19,892,266	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,871,699	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,162,296	0	0	0	6.00
7.00	Inventory	448,786	0	0	0	7.00
8.00	Prepaid expenses	374,952	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	24,167,289	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	295,110	0	0	0	12.00
13.00	Land improvements	1,687,647	0	0	0	13.00
14.00	Accumulated depreciation	-910,658	0	0	0	14.00
15.00	Buildings	16,506,311	0	0	0	15.00
16.00	Accumulated depreciation	-8,157,337	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	164,333	0	0	0	19.00
20.00	Accumulated depreciation	-161,990	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	12,593,688	0	0	0	23.00
24.00	Accumulated depreciation	-10,614,694	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	34,768	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,437,178	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	356,546	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	356,546	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,961,013	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	629,668	0	0	0	37.00
38.00	Salaries, wages, and fees payable	349,647	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	297,764	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	1,104,033	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,381,112	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,299,013	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)	5,299,013	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,680,125	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,280,888				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)	28,280,888	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,961,013	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/22/2017 1:11 pm

		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		25,860,016		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,420,872				2.00
3.00	Total (sum of line 1 and line 2)		28,280,888		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,280,888		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)		28,280,888		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/22/2017 1:11 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,924,132		1,924,132	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,924,132		1,924,132	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,924,132		1,924,132	17.00
18.00	Ancillary services	2,519,574	34,941,383	37,460,957	18.00
19.00	Outpatient services	0	0	0	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
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	ASSISTED LIVING	1,704,996	0	1,704,996	27.00
27.01	PROFESSIONAL FEES	273,978	2,303,713	2,577,691	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,422,680	37,245,096	43,667,776	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,289,686		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBT EXPENSE	1,821,663			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)		1,821,663		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)		22,111,349		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1332 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-3 | Date/Time Prepared: 11/22/2017 1:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,667,776	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,658,180	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,009,596	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,111,349	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,898,247	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	291,126	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	6,693	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	43,457	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	15,431	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT MONEY	157,432	24.00
24.01	OTHER REVENUE	44,175	24.01
25.00	Total other income (sum of lines 6-24)	558,314	25.00
26.00	Total (line 5 plus line 25)	2,456,561	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	35,689	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	35,689	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,420,872	29.00