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: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/22/2017 1:56 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/22/2017 Time: 1:56 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 ST. FRANCIS HOSPITAL (14-1350) 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.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	235,150	-185,727	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	77,196	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	312,346	-185,727	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 1:54 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1215 FRANCISCAN DRIVE	PO Box:			1.00
2.00	City: LITCHFIELD	State: IL	Zip Code: 62056	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	ST. FRANCIS HOSPITAL	141350	99914	1	12/01/2005	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	ST. FRANCIS HOSPITAL	14Z350	99914		05/31/2007	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2016	06/30/2017	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2017 1:54 pm

		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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2017 1:54 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 1:54 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	46,982	0	359,753	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 1:54 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	148005	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: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONA GOVERNMENT SERVICES	Contractor's Number: 00131	141.00
142.00	Street: 4736 LAVERNA ROAD	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62794	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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 1:54 pm

		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)	07/01/2015	06/30/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2017 1:54 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)	N			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/02/2017	Y	10/02/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/22/2017 1:54 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	Y	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?	Y		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.	Y		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.	Y		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.	PATTY	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	211 N BROADWAY STE 600, ST LOUIS, MO	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/22/2017 1:54 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.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2017 1:54 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	85,584.00	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	85,584.00	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	85,584.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		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: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2017 1:54 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)	2,511	545	4,091			1.00
2.00	HMO and other (see instructions)	273	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	470	0	470			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	119			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,981	545	4,680			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		336	412			13.00
14.00	Total (see instructions)	2,981	881	5,092	0.00	210.47	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	210.47	27.00
28.00	Observation Bed Days		116	473			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			75			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: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2017 1:54 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	655	260	1,316	1.00
2.00	HMO and other (see instructions)			65	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	655	260	1,316	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/22/2017 1:54 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)	0.285453	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,141,326	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	28,080,281	6.00
7.00	Medicaid cost (line 1 times line 6)	8,015,600	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)	1,310,008	484,474	1,794,482	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	373,946	484,474	858,420	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)	373,946	484,474	858,420	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)	2,988,504	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	797,173	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,226,419	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	1,762,085	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	932,238	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,790,658	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,790,658	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/22/2017 1:54 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		428,198	428,198	1,301,713	1,729,911	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,509,271	2,509,271	-1,312,031	1,197,240	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	91,808	2,353,369	2,445,177	0	2,445,177	4.00
5.01	00570	ADMITTING	469,286	84,637	553,923	-180,985	372,938	5.01
5.02	00540	PATIENT ACCOUNTING	0	561,851	561,851	0	561,851	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	1,229,254	5,920,846	7,150,100	60,586	7,210,686	5.03
6.00	00600	MAINTENANCE & REPAIRS	282,980	18,853	301,833	0	301,833	6.00
7.00	00700	OPERATION OF PLANT	61,591	1,057,731	1,119,322	-83	1,119,239	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	155,934	155,934	8.00
9.00	00900	HOUSEKEEPING	260,015	308,590	568,605	0	568,605	9.00
10.00	01000	DIETARY	337,346	285,946	623,292	-502,603	120,689	10.00
11.00	01100	CAFETERIA	0	0	0	502,603	502,603	11.00
13.00	01300	NURSING ADMINISTRATION	180,964	25,504	206,468	0	206,468	13.00
15.00	01500	PHARMACY	425,916	1,040,445	1,466,361	-852,596	613,765	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	179,502	359,235	538,737	32,584	571,321	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,547,862	412,728	2,960,590	-900,082	2,060,508	30.00
43.00	04300	NURSERY	0	0	0	107,550	107,550	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,091,381	1,771,517	2,862,898	-757,571	2,105,327	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	558,560	558,560	52.00
53.00	05300	ANESTHESIOLOGY	0	768,599	768,599	-20,076	748,523	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	878,803	411,988	1,290,791	-26,723	1,264,068	54.00
57.00	05700	CT SCAN	100,684	199,735	300,419	6,860	307,279	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	88,666	135,598	224,264	6,347	230,611	58.00
60.00	06000	LABORATORY	608,076	1,022,621	1,630,697	129,095	1,759,792	60.00
65.00	06500	RESPIRATORY THERAPY	347,903	207,446	555,349	16,305	571,654	65.00
66.00	06600	PHYSICAL THERAPY	135,103	823,513	958,616	-529	958,087	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	114,301	114,301	236,907	351,208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	604,883	604,883	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	852,149	852,149	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	107,732	12,096	119,828	0	119,828	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	237,313	980,785	1,218,098	-345	1,217,753	90.00
91.00	09100	EMERGENCY	1,129,019	1,427,579	2,556,598	-71,694	2,484,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,791,204	23,242,982	34,034,186	-53,242	33,980,944	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,064	29,064	0	29,064	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	131,901	319,608	451,509	34,048	485,557	192.00
194.00	07950	OTHER NONALLOWABLE	146,574	223,259	369,833	19,194	389,027	194.00
200.00		TOTAL (SUM OF LINES 118-199)	11,069,679	23,814,913	34,884,592	0	34,884,592	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/22/2017 1:54 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	0	1,729,911		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-834,621	362,619		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,784,314	5,229,491		4.00
5.01	00570	ADMITTING	0	372,938		5.01
5.02	00540	PATIENT ACCOUNTING	17,995	579,846		5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-638,033	6,572,653		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	301,833		6.00
7.00	00700	OPERATION OF PLANT	-6,205	1,113,034		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	155,934		8.00
9.00	00900	HOUSEKEEPING	0	568,605		9.00
10.00	01000	DIETARY	0	120,689		10.00
11.00	01100	CAFETERIA	0	502,603		11.00
13.00	01300	NURSING ADMINISTRATION	0	206,468		13.00
15.00	01500	PHARMACY	0	613,765		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-55	571,266		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-114,400	1,946,108		30.00
43.00	04300	NURSERY	0	107,550		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,105,327		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	558,560		52.00
53.00	05300	ANESTHESIOLOGY	-643,694	104,829		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20	1,264,048		54.00
57.00	05700	CT SCAN	0	307,279		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	230,611		58.00
60.00	06000	LABORATORY	0	1,759,792		60.00
65.00	06500	RESPIRATORY THERAPY	-121,118	450,536		65.00
66.00	06600	PHYSICAL THERAPY	0	958,087		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	351,208		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	604,883		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	852,149		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	119,828		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-853,241	364,512		90.00
91.00	09100	EMERGENCY	0	2,484,904		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-409,078	33,571,866		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,064		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	485,557		192.00
194.00	07950	OTHER NONALLOWABLE	0	389,027		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-409,078	34,475,514		200.00

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/22/2017 1:54 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - L&D AND NURSERY SAL & OTHER EXP				
1.00	NURSERY	43.00	99,766	15,403	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	518,133	79,997	2.00
	0		617,899	95,400	
	B - DRUG COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	852,149	1.00
	0		0	852,149	
	C - CAFETERIA SALARIES & OTHER COSTS				
1.00	CAFETERIA	11.00	272,025	230,578	1.00
	0		272,025	230,578	
	D - LAUNDRY COSTS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	155,934	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	0		0	155,934	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	309,221	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	532,569	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	841,790	
	F - LAB ADMINISTRATION COSTS				
1.00	LABORATORY	60.00	110,174	22,468	1.00
2.00		0.00	0	0	2.00
	0		110,174	22,468	
	G - MOB DEPRECIATION COSTS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	36,796	1.00
	0		0	36,796	
	H - SHARED SERVICES COSTS				
1.00	ADMITTING	5.01	12,870	0	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	32,584	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	9,328	0	3.00
4.00	OPERATING ROOM	50.00	10,864	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	4,392	0	5.00
6.00	CT SCAN	57.00	1,254	0	6.00
7.00	RESPIRATORY THERAPY	65.00	16,305	0	7.00
8.00	OTHER NONALLOWABLE	194.00	19,194	0	8.00
	0		106,791	0	
	I - BUILDING INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	26,478	1.00
	0		0	26,478	
	J - RADIOLOGY MANAGERS COST				
1.00	CT SCAN	57.00	9,730	0	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	6,732	0	2.00
	0		16,462	0	
	K - MEDICAL RECORDS COSTS FROM A&G				
1.00		0.00	0	0	1.00
	0		0	0	
	M - CASE MANAGEMENT TO A&G				
1.00	ADMINISTRATIVE & GENERAL	5.03	132,338	61,517	1.00
	0		132,338	61,517	
	O - SEGREGATE DIRECT COSTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	72,314	1.00
	0		0	72,314	

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/22/2017 1:54 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	P - DEPRECIATION EXPENSE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,275,235	1.00
	TOTALS		0	1,275,235	
500.00	Grand Total: Increases		1,255,689	3,670,659	500.00

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/22/2017 1:54 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - L&D AND NURSERY SAL & OTHER EXP						
1.00	ADULTS & PEDIATRICS	30.00	617,899	95,400	0		1.00
2.00		0.00	0	0	0		2.00
	0		617,899	95,400			
	B - DRUG COSTS						
1.00	PHARMACY	15.00	0	852,149	0		1.00
	0		0	852,149			
	C - CAFETERIA SALARIES & OTHER COSTS						
1.00	DIETARY	10.00	272,025	230,578	0		1.00
	0		272,025	230,578			
	D - LAUNDRY COSTS						
1.00	OPERATION OF PLANT	7.00	0	83	0		1.00
2.00	PHARMACY	15.00	0	447	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	61,953	0		3.00
4.00	NURSERY	43.00	0	2,754	0		4.00
5.00	OPERATING ROOM	50.00	0	22,412	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	14,303	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,653	0		7.00
8.00	CT SCAN	57.00	0	4,124	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	385	0		9.00
10.00	LABORATORY	60.00	0	3,547	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	529	0		11.00
12.00	CLINIC	90.00	0	345	0		12.00
13.00	EMERGENCY	91.00	0	27,651	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,748	0		14.00
	0		0	155,934			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	5,357	0		1.00
2.00	NURSERY	43.00	0	4,865	0		2.00
3.00	OPERATING ROOM	50.00	0	746,023	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	25,267	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	20,076	0		5.00
6.00	EMERGENCY	91.00	0	40,202	0		6.00
	0		0	841,790			
	F - LAB ADMINISTRATION COSTS						
1.00	ADULTS & PEDIATRICS	30.00	108,433	20,368	0		1.00
2.00	EMERGENCY	91.00	1,741	2,100	0		2.00
	0		110,174	22,468			
	G - MOB DEPRECIATION COSTS						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	36,796	9		1.00
	0		0	36,796			
	H - SHARED SERVICES COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.03	106,791	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	0		106,791	0			
	I - BUILDING INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.03	0	26,478	12		1.00
	0		0	26,478			
	J - RADIOLOGY MANAGERS COST						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	16,462	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		16,462	0			
	K - MEDICAL RECORDS COSTS FROM A&G						
1.00		0.00	0	0	0		1.00
	0		0	0			
	M - CASE MANAGEMENT TO A&G						
1.00	ADMITTING	5.01	132,338	61,517	0		1.00
	0		132,338	61,517			
	O - SEGREGATE DIRECT COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	72,314	0		1.00
	0		0	72,314			
	P - DEPRECIATION EXPENSE RECLASS						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,275,235	9		1.00
	TOTALS		0	1,275,235			
500.00	Grand Total: Decreases		1,255,689	3,670,659			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/22/2017 1:54 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	0	99,383	0	99,383	0	1.00
2.00	Land Improvements	99,383	1,823,616	0	1,823,616	0	2.00
3.00	Buildings and Fixtures	1,836,116	9,632,796	0	9,632,796	39,068	3.00
4.00	Building Improvements	35,053,876	0	0	0	35,053,876	4.00
5.00	Fixed Equipment	0	26,058,099	0	26,058,099	0	5.00
6.00	Movable Equipment	20,718,534	1,322,977	0	1,322,977	5,427,513	6.00
7.00	HIT designated Assets	0	5,136,661	0	5,136,661	0	7.00
8.00	Subtotal (sum of lines 1-7)	57,707,909	44,073,532	0	44,073,532	40,520,457	8.00
9.00	Reconciling Items	0	104,789	0	104,789	48,908	9.00
10.00	Total (line 8 minus line 9)	57,707,909	43,968,743	0	43,968,743	40,471,549	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	99,383	0	1.00
2.00	Land Improvements	1,922,999	0	2.00
3.00	Buildings and Fixtures	11,429,844	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	26,058,099	0	5.00
6.00	Movable Equipment	16,613,998	0	6.00
7.00	HIT designated Assets	5,136,661	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,260,984	0	8.00
9.00	Reconciling Items	55,881	0	9.00
10.00	Total (line 8 minus line 9)	61,205,103	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/22/2017 1:54 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	401,720	0	26,478	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,509,271	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,910,991	0	26,478	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	428,198		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,509,271		2.00
3.00	Total (sum of lines 1-2)	0	2,937,469		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2017 1:54 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	39,510,325	0	39,510,325	0.644951	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,750,659	0	21,750,659	0.355049	0	2.00
3.00	Total (sum of lines 1-2)	61,260,984	0	61,260,984	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	1,676,955	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	362,619	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,039,574	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	26,478	26,478	0	0	1,729,911	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	362,619	2.00
3.00	Total (sum of lines 1-2)	26,478	26,478	0	0	2,092,530	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/22/2017 1:54 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,205	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,732,410			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	1,061,774			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/22/2017 1:54 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	-834,621	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC INCOME	B	-267,940	ADMINISTRATIVE & GENERAL	5.03	0	33.00
33.01	BANK CHARGES	A	17,995	PATIENT ACCOUNTING	5.02	0	33.01
33.02			0		0.00	0	33.02
33.03	RADIOLOGY MISC REVENUE	B	-20	RADIOLOGY-DIAGNOSTIC	54.00	0	33.03
33.04	HIS MISC INCOME	B	-55	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	ALCOHOL BEVERAGE COST	A	-36	CLINIC	90.00	0	33.05
33.06	ALCOHOL BEVERAGE COST	A	-7	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	ALCOHOL BEVERAGE COST	A	-1,837	ADMINISTRATIVE & GENERAL	5.03	0	33.07
33.08	ADVERTISING COST	A	-43	ADMINISTRATIVE & GENERAL	5.03	0	33.08
33.09	DEFINED PENSION ADJUSTMENT	A	3,652,393	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	FUND DEVELOPMENT	A	-39,066	ADMINISTRATIVE & GENERAL	5.03	0	33.10
33.11	SELF-INS TO HOSP/EMP CLIMS	A	-867,830	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PHYSICIAN RECRUITMENT	A	-3,703	ADMINISTRATIVE & GENERAL	5.03	0	33.12
33.13	MEDICAID TAX ASSESSMENT	A	-1,326,652	ADMINISTRATIVE & GENERAL	5.03	0	33.13
33.14	LOBBYING EXPENSES	A	-12,847	ADMINISTRATIVE & GENERAL	5.03	0	33.14
33.15	MEALS TO NON-PROVIDERS	A	-47,968	ADMINISTRATIVE & GENERAL	5.03	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-409,078				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: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2017 1:54 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF-INS PREMIUMS	2,739,569	2,739,818	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY SVCS	4,027	4,027	2.00
3.00	5.03	ADMINISTRATIVE & GENERAL	CONTRACT SERVICES - HSHS	3,728,844	2,666,821	3.00
3.01	5.03	ADMINISTRATIVE & GENERAL	RELATED PARTY SVCS	504,377	504,377	3.01
3.02	5.01	ADMITTING	RELATED PARTY SVCS	17,699	17,699	3.02
3.03	5.02	PATIENT ACCOUNTING	RELATED PARTY SVCS	30,769	30,769	3.03
3.04	9.00	HOUSEKEEPING	RELATED PARTY SVCS	155	155	3.04
3.05	10.00	DIETARY	RELATED PARTY SVCS	622	622	3.05
3.06	13.00	NURSING ADMINISTRATION	RELATED PARTY SVCS	22	22	3.06
3.07	15.00	PHARMACY	RELATED PARTY SVCS	4,146	4,146	3.07
3.08	30.00	ADULTS & PEDIATRICS	RELATED PARTY SVCS	125,999	125,999	3.08
3.09	50.00	OPERATING ROOM	RELATED PARTY SVCS	18,809	18,809	3.09
3.10	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SVCS	6,099	6,099	3.10
3.11	57.00	CT SCAN	RELATED PARTY SVCS	428	428	3.11
3.12	58.00	MAGNETIC RESONANCE IMAGING (	RELATED PARTY SVCS	36	36	3.12
3.13	60.00	LABORATORY	RELATED PARTY SVCS	180,043	180,043	3.13
3.14	65.00	RESPIRATORY THERAPY	RELATED PARTY SVCS	110,838	110,838	3.14
3.15	66.00	PHYSICAL THERAPY	RELATED PARTY SVCS	400	400	3.15
3.16	90.00	CLINIC	RELATED PARTY SVCS	91,885	91,885	3.16
3.17	91.00	EMERGENCY	RELATED PARTY SVCS	1,342	1,342	3.17
3.18	0.00			0	0	3.18
3.19	192.00	PHYSICIANS' PRIVATE OFFICES	RELATED PARTY SVCS	43	43	3.19
3.20	194.00	OTHER NONALLOWABLE	RELATED PARTY SVCS	38,552	38,552	3.20
4.00	7.00	OPERATION OF PLANT	RELATED PARTY SVCS	22	22	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,604,726	6,542,952	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	B	HSHS	100.00	HSHS	0.00	6.00
7.00			0.00		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: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-1 Date/Time Prepared: 11/22/2017 1:54 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	-249	0		1.00
2.00	0	0		2.00
3.00	1,062,023	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
3.18	0	0		3.18
3.19	0	0		3.19
3.20	0	0		3.20
4.00	0	0		4.00
5.00	1,061,774			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	CORPORATE		6.00
7.00			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: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2017 1:54 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	53.00	ANESTHESIOLOGY	643,694	643,694	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	121,118	121,118	0	0	0	2.00
3.00	91.00	EMERGENCY	1,308,566	0	1,308,566	0	0	3.00
4.00	90.00	CLINIC	853,205	853,205	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	114,393	114,393	0	0	0	5.00
6.00	5.03	ADMINISTRATIVE & GENERAL	56,517	0	56,517	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			3,097,493	1,732,410	1,365,083		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	5.03	ADMINISTRATIVE & GENERAL	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	53.00	ANESTHESIOLOGY	0	0	0	643,694		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	121,118		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	90.00	CLINIC	0	0	0	853,205		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	114,393		5.00
6.00	5.03	ADMINISTRATIVE & GENERAL	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	1,732,410		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2017 1:54 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					7.47	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	5,739.50	4,684.75	619.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.82	60.61	40.41	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.41	40.41	30.31			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					463,866	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					283,943	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					747,809	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					25,014	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					772,823	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					772,823	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2017 1:54 pm

Physical Therapy — Cost

							1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
	PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00			48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00			49.00
	CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00
	DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.82	60.61	40.41	0.00			52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	772,823		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	772,823		63.00
64.00	Total cost of outside supplier services (from your records)	714,715		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2017 1:54 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		216	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		102	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		7.47	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	560.75	372.87	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.61	57.45	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.31	38.31	28.73			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	42,959	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	21,421	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	64,380	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	64,380	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	64,380	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	8,275	24.00
25.00	Assistants (line 4 times column 3, line 11)	2,930	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	11,205	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,375	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	13,580	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	13,580	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2017 1:54 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.61	57.45	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		64,380	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		13,580	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		77,960	63.00
64.00	Total cost of outside supplier services (from your records)		53,034	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		11,205	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		2,375	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		13,580	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		2,375	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		2,375	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2017 1:54 pm

Speech Pathology | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	111	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	7.47	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	164.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.61	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.81	36.81	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	12,109	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	12,109	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	12,109	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	73.61	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	57,416	22.00
23.00	Total salary equivalency (see instructions)	57,416	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	4,086	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	4,086	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	829	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	4,915	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	4,915	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2017 1:54 pm

Speech Pathology — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.61	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	57,416	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	4,915	58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00	
60.00	Overtime allowance (from column 5, line 56)	0	60.00	
61.00	Equipment cost (see instructions)	0	61.00	
62.00	Supplies (see instructions)	0	62.00	
63.00	Total allowance (sum of lines 57-62)	62,331	63.00	
64.00	Total cost of outside supplier services (from your records)	9,870	64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00	
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,086	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	829	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27	4,915	100.02	
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	829	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01	
101.02	Line 34 = sum of lines 27 and 31	829	101.02	
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01	
102.02	Line 35 = sum of lines 31 and 32	0	102.02	

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/22/2017 1:54 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	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,729,911	1,729,911				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	362,619		362,619			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,229,491	6,266	1,677	5,237,434		4.00
5.01	00570	ADMITTING	372,938	34,776	1,386	166,895	575,995	5.01
5.02	00540	PATIENT ACCOUNTING	579,846	2,287	0	0	0	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	6,572,653	172,515	22,039	598,653	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	301,833	0	0	135,007	0	6.00
7.00	00700	OPERATION OF PLANT	1,113,034	371,049	0	29,384	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	155,934	15,087	0	0	0	8.00
9.00	00900	HOUSEKEEPING	568,605	32,955	375	124,051	0	9.00
10.00	01000	DIETARY	120,689	89,371	3,738	31,164	0	10.00
11.00	01100	CAFETERIA	502,603	29,223	0	129,780	0	11.00
13.00	01300	NURSING ADMINISTRATION	206,468	10,889	6,531	86,336	0	13.00
15.00	01500	PHARMACY	613,765	18,630	9,559	203,200	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	571,266	19,145	0	101,184	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,946,108	199,015	31,639	873,486	24,085	30.00
43.00	04300	NURSERY	107,550	8,711	0	47,597	1,396	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,105,327	145,658	69,237	525,870	41,368	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	558,560	42,250	0	247,196	7,251	52.00
53.00	05300	ANESTHESIOLOGY	104,829	4,672	5,246	0	33,108	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,264,048	90,974	47,938	413,510	73,324	54.00
57.00	05700	CT SCAN	307,279	5,276	3,278	53,276	86,972	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,611	15,641	119,970	45,513	36,022	58.00
60.00	06000	LABORATORY	1,759,792	47,180	7,654	342,670	77,312	60.00
65.00	06500	RESPIRATORY THERAPY	450,536	21,501	5,310	173,760	11,429	65.00
66.00	06600	PHYSICAL THERAPY	958,087	49,091	1,514	64,456	31,759	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	351,208	25,025	0	0	17,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	604,883	0	0	0	12,373	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	852,149	0	0	0	42,445	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	119,828	12,631	306	51,398	12,962	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	364,512	23,471	851	113,220	10,676	90.00
91.00	09100	EMERGENCY	2,484,904	78,917	24,047	537,813	55,885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,571,866	1,572,206	362,295	5,095,419	575,995	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,064	9,295	37	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	485,557	145,569	0	62,929	0	192.00
194.00	07950	OTHER NONALLOWABLE	389,027	2,841	287	79,086	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	34,475,514	1,729,911	362,619	5,237,434	575,995	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/22/2017 1:54 pm

		Cost Center Description	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5A.02	5.03	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING	582,133					5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	7,365,860	7,365,860			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	436,840	118,692	555,532		6.00
7.00	00700	OPERATION OF PLANT	0	1,513,467	411,218	136,143	2,060,828	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	171,021	46,467	5,535	27,200	8.00
9.00	00900	HOUSEKEEPING	0	725,986	197,255	12,092	59,416	9.00
10.00	01000	DIETARY	0	244,962	66,558	32,791	161,132	10.00
11.00	01100	CAFETERIA	0	661,606	179,762	10,722	52,688	11.00
13.00	01300	NURSING ADMINISTRATION	0	310,224	84,290	3,995	19,633	13.00
15.00	01500	PHARMACY	0	845,154	229,633	6,836	33,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	691,595	187,911	7,025	34,518	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,342	3,098,675	841,929	73,021	358,818	30.00
43.00	04300	NURSERY	1,411	166,665	45,284	3,196	15,706	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,807	2,929,267	795,899	53,444	262,617	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,329	862,586	234,370	15,502	76,176	52.00
53.00	05300	ANESTHESIOLOGY	33,460	181,315	49,264	1,714	8,424	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,104	1,963,898	533,603	33,380	164,024	54.00
57.00	05700	CT SCAN	87,908	543,989	147,805	1,936	9,513	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	36,405	484,162	131,550	5,739	28,200	58.00
60.00	06000	LABORATORY	78,135	2,312,743	628,386	17,311	85,064	60.00
65.00	06500	RESPIRATORY THERAPY	11,551	674,087	183,153	7,889	38,766	65.00
66.00	06600	PHYSICAL THERAPY	32,096	1,137,003	308,931	18,012	88,509	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,815	411,676	111,855	9,182	45,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,505	629,761	171,110	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,897	937,491	254,722	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	13,099	210,224	57,119	4,635	22,774	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,790	523,520	142,244	8,612	42,318	90.00
91.00	09100	EMERGENCY	56,479	3,238,045	879,800	28,956	142,285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	582,133	33,271,822	7,038,810	497,668	1,776,491	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,396	10,432	3,411	16,759	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	694,055	188,579	53,411	262,456	192.00
194.00	07950	OTHER NONALLOWABLE	0	471,241	128,039	1,042	5,122	194.00
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)	582,133	34,475,514	7,365,860	555,532	2,060,828	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/22/2017 1:54 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	250,223					8.00
9.00	00900	HOUSEKEEPING	0	994,749				9.00
10.00	01000	DIETARY	0	0	505,443			10.00
11.00	01100	CAFETERIA	0	0	0	904,778		11.00
13.00	01300	NURSING ADMINISTRATION	0	5,452	0	6,241	429,835	13.00
15.00	01500	PHARMACY	0	0	0	27,805	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	26,137	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	102,295	215,513	505,443	228,247	197,145	30.00
43.00	04300	NURSERY	4,423	10,849	0	8,589	7,418	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,392	149,109	0	108,749	93,930	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,971	56,481	0	44,674	38,586	52.00
53.00	05300	ANESTHESIOLOGY	0	11,558	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,476	78,834	0	90,274	0	54.00
57.00	05700	CT SCAN	6,685	9,704	0	10,381	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,540	0	0	7,971	0	58.00
60.00	06000	LABORATORY	5,933	45,414	0	71,861	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,446	23,770	0	37,939	0	65.00
66.00	06600	PHYSICAL THERAPY	714	31,403	0	50,791	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,397	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,849	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	63,841	0	10,133	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	549	8,505	0	28,052	0	90.00
91.00	09100	EMERGENCY	39,216	97,807	0	107,389	92,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	243,640	862,486	505,443	865,233	429,835	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,798	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,583	127,465	0	27,373	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	12,172	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	250,223	994,749	505,443	904,778	429,835	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/22/2017 1:54 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
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
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	1,143,018					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	947,186				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	227,811	0	5,848,897	0	30.00
43.00	04300	NURSERY	0	12,414	0	274,544	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	137,149	0	4,562,556	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	64,470	0	1,415,816	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	252,275	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	107,845	0	2,992,334	0	54.00
57.00	05700	CT SCAN	0	13,895	0	743,908	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	11,870	0	673,032	0	58.00
60.00	06000	LABORATORY	0	89,370	0	3,256,082	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	45,317	0	1,015,367	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,810	0	1,652,173	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	583,230	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	800,871	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,143,018	0	0	2,384,080	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	13,405	0	382,131	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	29,528	0	783,328	0	90.00
91.00	09100	EMERGENCY	0	140,264	0	4,766,518	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,143,018	910,148	0	32,387,142	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	73,796	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,412	0	1,376,334	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	20,626	0	638,242	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,143,018	947,186	0	34,475,514	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/22/2017 1:54 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00540	PATIENT ACCOUNTING			5.02
5.03	00550	ADMINISTRATIVE & GENERAL			5.03
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
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,848,897		30.00
43.00	04300	NURSERY	274,544		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	4,562,556		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,415,816		52.00
53.00	05300	ANESTHESIOLOGY	252,275		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,992,334		54.00
57.00	05700	CT SCAN	743,908		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	673,032		58.00
60.00	06000	LABORATORY	3,256,082		60.00
65.00	06500	RESPIRATORY THERAPY	1,015,367		65.00
66.00	06600	PHYSICAL THERAPY	1,652,173		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	583,230		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	800,871		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,384,080		73.00
76.00	03020	OTHER	0		76.00
76.97	07697	CARDIAC REHABILITATION	382,131		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	783,328		90.00
91.00	09100	EMERGENCY	4,766,518		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,387,142		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	73,796		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,376,334		192.00
194.00	07950	OTHER NONALLOWABLE	638,242		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	34,475,514		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/22/2017 1:54 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	880	6,266	1,677	8,823	8,823	4.00
5.01	00570	ADMITTING	2,919	34,776	1,386	39,081	281	5.01
5.02	00540	PATIENT ACCOUNTING	0	2,287	0	2,287	0	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	1,367,737	172,515	22,039	1,562,291	1,009	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	228	6.00
7.00	00700	OPERATION OF PLANT	7,279	371,049	0	378,328	50	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,087	0	15,087	0	8.00
9.00	00900	HOUSEKEEPING	390	32,955	375	33,720	209	9.00
10.00	01000	DIETARY	256	89,371	3,738	93,365	53	10.00
11.00	01100	CAFETERIA	0	29,223	0	29,223	219	11.00
13.00	01300	NURSING ADMINISTRATION	200	10,889	6,531	17,620	145	13.00
15.00	01500	PHARMACY	101,589	18,630	9,559	129,778	342	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,362	19,145	0	23,507	171	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,546	199,015	31,639	234,200	1,467	30.00
43.00	04300	NURSERY	0	8,711	0	8,711	80	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,132	145,658	69,237	220,027	886	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	42,250	0	42,250	417	52.00
53.00	05300	ANESTHESIOLOGY	1,160	4,672	5,246	11,078	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	925	90,974	47,938	139,837	697	54.00
57.00	05700	CT SCAN	0	5,276	3,278	8,554	90	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,641	119,970	135,611	77	58.00
60.00	06000	LABORATORY	69,788	47,180	7,654	124,622	577	60.00
65.00	06500	RESPIRATORY THERAPY	18,747	21,501	5,310	45,558	293	65.00
66.00	06600	PHYSICAL THERAPY	371	49,091	1,514	50,976	109	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,815	25,025	0	39,840	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	899	12,631	306	13,836	87	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	39	23,471	851	24,361	191	90.00
91.00	09100	EMERGENCY	3,349	78,917	24,047	106,313	906	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,604,383	1,572,206	362,295	3,538,884	8,584	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	76	9,295	37	9,408	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,539	145,569	0	154,108	106	192.00
194.00	07950	OTHER NONALLOWABLE	11,889	2,841	287	15,017	133	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,624,887	1,729,911	362,619	3,717,417	8,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/22/2017 1:54 pm

		Cost Center Description	ADMITTING	PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.01	5.02	5.03	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	39,362					5.01
5.02	00540	PATIENT ACCOUNTING	0	2,287				5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	0	1,563,300			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	25,191	25,419		6.00
7.00	00700	OPERATION OF PLANT	0	0	87,276	6,231	471,885	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	9,862	253	6,228	8.00
9.00	00900	HOUSEKEEPING	0	0	41,865	553	13,605	9.00
10.00	01000	DIETARY	0	0	14,126	1,500	36,896	10.00
11.00	01100	CAFETERIA	0	0	38,152	491	12,064	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	17,889	183	4,496	13.00
15.00	01500	PHARMACY	0	0	48,737	313	7,691	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	39,882	321	7,904	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,646	95	178,688	3,341	82,160	30.00
43.00	04300	NURSERY	95	6	9,611	146	3,596	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,827	163	168,919	2,445	60,134	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	496	29	49,742	709	17,443	52.00
53.00	05300	ANESTHESIOLOGY	2,263	130	10,456	78	1,929	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,012	289	113,250	1,527	37,558	54.00
57.00	05700	CT SCAN	5,937	360	31,370	89	2,178	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,462	142	27,920	263	6,457	58.00
60.00	06000	LABORATORY	5,284	305	133,367	792	19,478	60.00
65.00	06500	RESPIRATORY THERAPY	781	45	38,872	361	8,877	65.00
66.00	06600	PHYSICAL THERAPY	2,171	125	65,566	824	20,267	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,205	69	23,740	420	10,331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	846	49	36,316	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,901	167	54,061	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	886	51	12,123	212	5,215	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	730	42	30,189	394	9,690	90.00
91.00	09100	EMERGENCY	3,820	220	186,718	1,325	32,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,362	2,287	1,493,888	22,771	406,777	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,214	156	3,838	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	40,023	2,444	60,097	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	27,175	48	1,173	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	39,362	2,287	1,563,300	25,419	471,885	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/22/2017 1:54 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,430					8.00
9.00	00900	HOUSEKEEPING	0	89,952				9.00
10.00	01000	DIETARY	0	0	145,940			10.00
11.00	01100	CAFETERIA	0	0	0	80,149		11.00
13.00	01300	NURSING ADMINISTRATION	0	493	0	553	41,379	13.00
15.00	01500	PHARMACY	0	0	0	2,463	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,315	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,848	19,489	145,940	20,219	18,979	30.00
43.00	04300	NURSERY	556	981	0	761	714	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,069	13,483	0	9,633	9,042	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,885	5,107	0	3,957	3,715	52.00
53.00	05300	ANESTHESIOLOGY	0	1,045	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,572	7,129	0	7,997	0	54.00
57.00	05700	CT SCAN	840	878	0	920	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	445	0	0	706	0	58.00
60.00	06000	LABORATORY	745	4,107	0	6,366	0	60.00
65.00	06500	RESPIRATORY THERAPY	558	2,149	0	3,361	0	65.00
66.00	06600	PHYSICAL THERAPY	90	2,840	0	4,499	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	488	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,417	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	5,773	0	898	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	69	769	0	2,485	0	90.00
91.00	09100	EMERGENCY	4,926	8,844	0	9,513	8,929	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,603	77,992	145,940	76,646	41,379	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	434	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	827	11,526	0	2,425	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	1,078	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,430	89,952	145,940	80,149	41,379	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
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
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	189,324					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74,100				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	17,822	0	736,894	0	30.00
43.00	04300	NURSERY	0	971	0	26,228	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,729	0	502,357	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,044	0	131,794	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,979	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,437	0	324,305	0	54.00
57.00	05700	CT SCAN	0	1,087	0	52,303	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	929	0	175,012	0	58.00
60.00	06000	LABORATORY	0	6,991	0	302,634	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,545	0	104,400	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,315	0	148,782	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	76,093	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	37,211	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	189,324	0	0	250,870	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,049	0	40,130	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,310	0	71,230	0	90.00
91.00	09100	EMERGENCY	0	10,973	0	375,067	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	189,324	71,202	0	3,382,289	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16,050	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,284	0	272,840	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	1,614	0	46,238	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	189,324	74,100	0	3,717,417	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00540	PATIENT ACCOUNTING			5.02
5.03	00550	ADMINISTRATIVE & GENERAL			5.03
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
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	736,894		30.00
43.00	04300	NURSERY	26,228		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	502,357		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	131,794		52.00
53.00	05300	ANESTHESIOLOGY	26,979		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	324,305		54.00
57.00	05700	CT SCAN	52,303		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	175,012		58.00
60.00	06000	LABORATORY	302,634		60.00
65.00	06500	RESPIRATORY THERAPY	104,400		65.00
66.00	06600	PHYSICAL THERAPY	148,782		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	76,093		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,211		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	250,870		73.00
76.00	03020	OTHER	0		76.00
76.97	07697	CARDIAC REHABILITATION	40,130		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	71,230		90.00
91.00	09100	EMERGENCY	375,067		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,382,289		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,050		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	272,840		192.00
194.00	07950	OTHER NONALLOWABLE	46,238		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	3,717,417		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUES)	PATIENT ACCOUNTING (GROSS REVENUES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	174,751					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,156,973				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	633	5,351	10,977,871			4.00
5.01	00570	ADMITTING	3,513	4,421	349,818	113,458,745		5.01
5.02	00540	PATIENT ACCOUNTING	231	0	0	0	113,458,745	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	17,427	70,318	1,254,801	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	282,980	0	0	6.00
7.00	00700	OPERATION OF PLANT	37,482	0	61,591	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,524	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,329	1,196	260,015	0	0	9.00
10.00	01000	DIETARY	9,028	11,926	65,321	0	0	10.00
11.00	01100	CAFETERIA	2,952	0	272,025	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,100	20,838	180,964	0	0	13.00
15.00	01500	PHARMACY	1,882	30,498	425,916	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,934	0	212,086	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,104	100,948	1,830,858	4,744,032	4,744,032	30.00
43.00	04300	NURSERY	880	0	99,766	275,017	275,017	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,714	220,907	1,102,245	8,148,021	8,148,021	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,268	0	518,133	1,428,299	1,428,299	52.00
53.00	05300	ANESTHESIOLOGY	472	16,739	0	6,521,228	6,521,228	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,190	152,952	866,733	14,442,408	14,442,408	54.00
57.00	05700	CT SCAN	533	10,459	111,668	17,137,226	17,137,226	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,580	382,777	95,398	7,095,191	7,095,191	58.00
60.00	06000	LABORATORY	4,766	24,420	718,250	15,227,937	15,227,937	60.00
65.00	06500	RESPIRATORY THERAPY	2,172	16,943	364,208	2,251,163	2,251,163	65.00
66.00	06600	PHYSICAL THERAPY	4,959	4,832	135,103	6,255,380	6,255,380	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,528	0	0	3,472,102	3,472,102	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,437,111	2,437,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,360,283	8,360,283	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,276	976	107,732	2,552,991	2,552,991	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,371	2,715	237,313	2,102,859	2,102,859	90.00
91.00	09100	EMERGENCY	7,972	76,723	1,127,278	11,007,497	11,007,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	158,820	1,155,939	10,680,202	113,458,745	113,458,745	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	939	118	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,705	0	131,901	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	287	916	165,768	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,729,911	362,619	5,237,434	575,995	582,133	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.899291	0.313420	0.477090	0.005077	0.005131	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,823	39,362	2,287	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000804	0.000347	0.000020	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:54 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5A.03	5.03	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-7,365,860	27,109,654				5.03
6.00	00600	MAINTENANCE & REPAIRS	0	436,840	152,947			6.00
7.00	00700	OPERATION OF PLANT	0	1,513,467	37,482	115,465		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	171,021	1,524	1,524	194,463	8.00
9.00	00900	HOUSEKEEPING	0	725,986	3,329	3,329	0	9.00
10.00	01000	DIETARY	0	244,962	9,028	9,028	0	10.00
11.00	01100	CAFETERIA	0	661,606	2,952	2,952	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	310,224	1,100	1,100	0	13.00
15.00	01500	PHARMACY	0	845,154	1,882	1,882	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	691,595	1,934	1,934	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,098,675	20,104	20,104	79,500	30.00
43.00	04300	NURSERY	0	166,665	880	880	3,437	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,929,267	14,714	14,714	25,174	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	862,586	4,268	4,268	17,852	52.00
53.00	05300	ANESTHESIOLOGY	0	181,315	472	472	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,963,898	9,190	9,190	15,913	54.00
57.00	05700	CT SCAN	0	543,989	533	533	5,195	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	484,162	1,580	1,580	2,751	58.00
60.00	06000	LABORATORY	0	2,312,743	4,766	4,766	4,611	60.00
65.00	06500	RESPIRATORY THERAPY	0	674,087	2,172	2,172	3,455	65.00
66.00	06600	PHYSICAL THERAPY	0	1,137,003	4,959	4,959	555	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	411,676	2,528	2,528	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	629,761	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	937,491	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	210,224	1,276	1,276	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	523,520	2,371	2,371	427	90.00
91.00	09100	EMERGENCY	0	3,238,045	7,972	7,972	30,477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,365,860	25,905,962	137,016	99,534	189,347	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,396	939	939	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	694,055	14,705	14,705	5,116	192.00
194.00	07950	OTHER NONALLOWABLE	0	471,241	287	287	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		7,365,860	555,532	2,060,828	250,223	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.271706	3.632186	17.848075	1.286738	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,563,300	25,419	471,885	31,430	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.057666	0.166195	4.086823	0.161625	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:54 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
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	18,246					9.00
10.00	01000	DIETARY	0	27,969				10.00
11.00	01100	CAFETERIA	0	0	14,643			11.00
13.00	01300	NURSING ADMINISTRATION	100	0	101	8,054		13.00
15.00	01500	PHARMACY	0	0	450	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	423	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,953	27,969	3,694	3,694	0	30.00
43.00	04300	NURSERY	199	0	139	139	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,735	0	1,760	1,760	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,036	0	723	723	0	52.00
53.00	05300	ANESTHESIOLOGY	212	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,446	0	1,461	0	0	54.00
57.00	05700	CT SCAN	178	0	168	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	129	0	0	58.00
60.00	06000	LABORATORY	833	0	1,163	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	436	0	614	0	0	65.00
66.00	06600	PHYSICAL THERAPY	576	0	822	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	896	0	0	0	100	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,171	0	164	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	156	0	454	0	0	90.00
91.00	09100	EMERGENCY	1,794	0	1,738	1,738	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,820	27,969	14,003	8,054	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	88	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,338	0	443	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	197	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	994,749	505,443	904,778	429,835	1,143,018	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	54.518744	18.071543	61.789114	53.369133	11,430.180000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	89,952	145,940	80,149	41,379	189,324	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.929957	5.217920	5.473537	5.137696	1,893.240000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 1:54 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS SALARIES)	SOCIAL SERVICE (TIME SPENT)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00540	PATIENT ACCOUNTING				5.02
5.03	00550	ADMINISTRATIVE & GENERAL				5.03
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
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,612,354			16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,830,858	0		30.00
43.00	04300	NURSERY	99,766	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,102,245	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	518,133	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	866,733	0		54.00
57.00	05700	CT SCAN	111,668	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	95,398	0		58.00
60.00	06000	LABORATORY	718,250	0		60.00
65.00	06500	RESPIRATORY THERAPY	364,208	0		65.00
66.00	06600	PHYSICAL THERAPY	135,103	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	107,732	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	237,313	0		90.00
91.00	09100	EMERGENCY	1,127,278	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,314,685	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	131,901	0		192.00
194.00	07950	OTHER NONALLOWABLE	165,768	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	947,186	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.124427	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,100	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009734	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:54 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	5,848,897		5,848,897	0	0	30.00
43.00	04300	NURSERY	274,544		274,544	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,562,556		4,562,556	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,415,816		1,415,816	0	0	52.00
53.00	05300	ANESTHESIOLOGY	252,275		252,275	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,992,334		2,992,334	0	0	54.00
57.00	05700	CT SCAN	743,908		743,908	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	673,032		673,032	0	0	58.00
60.00	06000	LABORATORY	3,256,082		3,256,082	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,015,367	0	1,015,367	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,652,173	0	1,652,173	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	583,230		583,230	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	800,871		800,871	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,384,080		2,384,080	0	0	73.00
76.00	03020	OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	382,131		382,131	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	783,328		783,328	0	0	90.00
91.00	09100	EMERGENCY	4,766,518		4,766,518	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	547,871		547,871		0	92.00
200.00		Subtotal (see instructions)	32,935,013	0	32,935,013	0	0	200.00
201.00		Less Observation Beds	547,871		547,871		0	201.00
202.00		Total (see instructions)	32,387,142	0	32,387,142	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:54 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	4,108,171		4,108,171			30.00
43.00	04300	NURSERY	275,017		275,017			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,279,209	6,868,812	8,148,021	0.559959	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	558,373	869,926	1,428,299	0.991260	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,266,485	5,254,743	6,521,228	0.038685	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,233,562	13,208,846	14,442,408	0.207191	0.000000	54.00
57.00	05700	CT SCAN	1,485,171	15,652,055	17,137,226	0.043409	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	263,490	6,831,701	7,095,191	0.094857	0.000000	58.00
60.00	06000	LABORATORY	3,514,639	11,713,298	15,227,937	0.213823	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	505,250	1,745,913	2,251,163	0.451041	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,271,108	4,984,272	6,255,380	0.264120	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,461,828	2,010,274	3,472,102	0.167976	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,003,443	433,668	2,437,111	0.328615	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,963,851	5,396,432	8,360,283	0.285167	0.000000	73.00
76.00	03020	OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	220,305	2,332,686	2,552,991	0.149680	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,370	2,101,489	2,102,859	0.372506	0.000000	90.00
91.00	09100	EMERGENCY	1,268,313	9,739,184	11,007,497	0.433025	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	635,861	635,861	0.861621	0.000000	92.00
200.00		Subtotal (see instructions)	23,679,585	89,779,160	113,458,745			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,679,585	89,779,160	113,458,745			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:54 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OTHER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:54 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	5,848,897		5,848,897	0	5,848,897	30.00
43.00	04300	NURSERY	274,544		274,544	0	274,544	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,562,556		4,562,556	0	4,562,556	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,415,816		1,415,816	0	1,415,816	52.00
53.00	05300	ANESTHESIOLOGY	252,275		252,275	0	252,275	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,992,334		2,992,334	0	2,992,334	54.00
57.00	05700	CT SCAN	743,908		743,908	0	743,908	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	673,032		673,032	0	673,032	58.00
60.00	06000	LABORATORY	3,256,082		3,256,082	0	3,256,082	60.00
65.00	06500	RESPIRATORY THERAPY	1,015,367	0	1,015,367	0	1,015,367	65.00
66.00	06600	PHYSICAL THERAPY	1,652,173	0	1,652,173	0	1,652,173	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	583,230		583,230	0	583,230	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	800,871		800,871	0	800,871	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,384,080		2,384,080	0	2,384,080	73.00
76.00	03020	OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	382,131		382,131	0	382,131	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	783,328		783,328	0	783,328	90.00
91.00	09100	EMERGENCY	4,766,518		4,766,518	0	4,766,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	547,871		547,871		547,871	92.00
200.00		Subtotal (see instructions)	32,935,013	0	32,935,013	0	32,935,013	200.00
201.00		Less Observation Beds	547,871		547,871		547,871	201.00
202.00		Total (see instructions)	32,387,142	0	32,387,142	0	32,387,142	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:54 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	4,108,171		4,108,171			30.00
43.00	04300	NURSERY	275,017		275,017			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,279,209	6,868,812	8,148,021	0.559959	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	558,373	869,926	1,428,299	0.991260	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,266,485	5,254,743	6,521,228	0.038685	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,233,562	13,208,846	14,442,408	0.207191	0.000000	54.00
57.00	05700	CT SCAN	1,485,171	15,652,055	17,137,226	0.043409	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	263,490	6,831,701	7,095,191	0.094857	0.000000	58.00
60.00	06000	LABORATORY	3,514,639	11,713,298	15,227,937	0.213823	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	505,250	1,745,913	2,251,163	0.451041	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,271,108	4,984,272	6,255,380	0.264120	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,461,828	2,010,274	3,472,102	0.167976	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,003,443	433,668	2,437,111	0.328615	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,963,851	5,396,432	8,360,283	0.285167	0.000000	73.00
76.00	03020	OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	220,305	2,332,686	2,552,991	0.149680	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,370	2,101,489	2,102,859	0.372506	0.000000	90.00
91.00	09100	EMERGENCY	1,268,313	9,739,184	11,007,497	0.433025	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	635,861	635,861	0.861621	0.000000	92.00
200.00		Subtotal (see instructions)	23,679,585	89,779,160	113,458,745			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,679,585	89,779,160	113,458,745			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 1:54 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OTHER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/22/2017 1:54 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	502,357	8,148,021	0.061654	596,910	36,802	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	131,794	1,428,299	0.092273	0	0	52.00
53.00	05300	ANESTHESIOLOGY	26,979	6,521,228	0.004137	611,874	2,531	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	324,305	14,442,408	0.022455	638,808	14,344	54.00
57.00	05700	CT SCAN	52,303	17,137,226	0.003052	421,056	1,285	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	175,012	7,095,191	0.024666	155,439	3,834	58.00
60.00	06000	LABORATORY	302,634	15,227,937	0.019874	1,378,789	27,402	60.00
65.00	06500	RESPIRATORY THERAPY	104,400	2,251,163	0.046376	329,969	15,303	65.00
66.00	06600	PHYSICAL THERAPY	148,782	6,255,380	0.023785	618,157	14,703	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	76,093	3,472,102	0.021916	639,288	14,011	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,211	2,437,111	0.015268	1,128,060	17,223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	250,870	8,360,283	0.030007	1,209,445	36,292	73.00
76.00	03020	OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	40,130	2,552,991	0.015719	60,945	958	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	71,230	2,102,859	0.033873	207	7	90.00
91.00	09100	EMERGENCY	375,067	11,007,497	0.034074	3,976	135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	69,026	635,861	0.108555	0	0	92.00
200.00		Total (lines 50-199)	2,688,193	109,075,557		7,792,923	184,830	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/22/2017 1:54 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/22/2017 1:54 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	8,148,021	0.000000	0.000000	596,910	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,428,299	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	6,521,228	0.000000	0.000000	611,874	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,442,408	0.000000	0.000000	638,808	54.00
57.00	05700	CT SCAN	0	17,137,226	0.000000	0.000000	421,056	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,095,191	0.000000	0.000000	155,439	58.00
60.00	06000	LABORATORY	0	15,227,937	0.000000	0.000000	1,378,789	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,251,163	0.000000	0.000000	329,969	65.00
66.00	06600	PHYSICAL THERAPY	0	6,255,380	0.000000	0.000000	618,157	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,472,102	0.000000	0.000000	639,288	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,437,111	0.000000	0.000000	1,128,060	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,360,283	0.000000	0.000000	1,209,445	73.00
76.00	03020	OTHER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,552,991	0.000000	0.000000	60,945	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,102,859	0.000000	0.000000	207	90.00
91.00	09100	EMERGENCY	0	11,007,497	0.000000	0.000000	3,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	635,861	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	109,075,557			7,792,923	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/22/2017 1:54 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OTHER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/22/2017 1:54 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	0.559959	0	2,143,144	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.991260	0	851	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038685	0	1,504,442	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.207191	0	4,824,938	0	0	54.00
57.00	05700	CT SCAN	0.043409	0	6,051,779	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.094857	0	2,092,414	0	0	58.00
60.00	06000	LABORATORY	0.213823	0	4,659,282	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.451041	0	695,844	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264120	0	1,636,992	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.167976	0	683,862	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.328615	0	111,115	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285167	0	2,468,617	1,797	0	73.00
76.00	03020	OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.149680	0	1,117,731	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.372506	0	446,637	0	0	90.00
91.00	09100	EMERGENCY	0.433025	0	3,364,570	1,436	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861621	0	367,023	0	0	92.00
200.00		Subtotal (see instructions)		0	32,169,241	3,233	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	32,169,241	3,233	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/22/2017 1:54 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	1,200,073	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	844	0		52.00
53.00	05300	ANESTHESIOLOGY	58,199	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	999,684	0		54.00
57.00	05700	CT SCAN	262,702	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	198,480	0		58.00
60.00	06000	LABORATORY	996,262	0		60.00
65.00	06500	RESPIRATORY THERAPY	313,854	0		65.00
66.00	06600	PHYSICAL THERAPY	432,362	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,872	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,514	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	703,968	512		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	167,302	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	166,375	0		90.00
91.00	09100	EMERGENCY	1,456,943	622		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	316,235	0		92.00
200.00		Subtotal (see instructions)	7,424,669	1,134		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,424,669	1,134		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/22/2017 1:54 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	0.559959	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.991260	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038685	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.207191	0	0	0	0	54.00
57.00	05700	CT SCAN	0.043409	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.094857	0	0	0	0	58.00
60.00	06000	LABORATORY	0.213823	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.451041	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264120	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.167976	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.328615	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285167	0	0	0	0	73.00
76.00	03020	OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.149680	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.372506	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.433025	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861621	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: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/22/2017 1:54 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 1:54 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)	5,153	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,564	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,091	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	235	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)	235	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	60	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)	59	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,511	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)	235	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)	235	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	150.15	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	153.39	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,848,897	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)	9,009	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)	9,050	25.00
26.00	Total swing-bed cost (see instructions)	562,455	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,286,442	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)	5,286,442	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)	1,158.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,908,466	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,908,466	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 1:54 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)	0	0	0.00	0	0	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)	1,964,104	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,872,570	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)	272,198	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	272,198	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	544,396	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)	473	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,158.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	547,871	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 1:54 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	736,894	5,848,897	0.125989	547,871	69,026	90.00
91.00	Nursing School cost	0	5,848,897	0.000000	547,871	0	91.00
92.00	Allied health cost	0	5,848,897	0.000000	547,871	0	92.00
93.00	All other Medical Education	0	5,848,897	0.000000	547,871	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/22/2017 1:54 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		2,186,064		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.559959	596,910	334,245	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.991260	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038685	611,874	23,670	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.207191	638,808	132,355	54.00
57.00	05700	CT SCAN	0.043409	421,056	18,278	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.094857	155,439	14,744	58.00
60.00	06000	LABORATORY	0.213823	1,378,789	294,817	60.00
65.00	06500	RESPIRATORY THERAPY	0.451041	329,969	148,830	65.00
66.00	06600	PHYSICAL THERAPY	0.264120	618,157	163,268	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.167976	639,288	107,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.328615	1,128,060	370,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285167	1,209,445	344,894	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.149680	60,945	9,122	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.372506	207	77	90.00
91.00	09100	EMERGENCY	0.433025	3,976	1,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861621	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,792,923	1,964,104	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)		7,792,923		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3

Component CCN: 14-Z350 | Date/Time Prepared: 11/22/2017 1:54 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.559959	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.991260	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038685	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.207191	22,514	4,665	54.00
57.00	05700	CT SCAN	0.043409	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.094857	0	0	58.00
60.00	06000	LABORATORY	0.213823	83,675	17,892	60.00
65.00	06500	RESPIRATORY THERAPY	0.451041	14,412	6,500	65.00
66.00	06600	PHYSICAL THERAPY	0.264120	306,103	80,848	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.167976	44,054	7,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.328615	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285167	108,042	30,810	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.149680	2,926	438	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.372506	0	0	90.00
91.00	09100	EMERGENCY	0.433025	309	134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861621	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		582,035	148,687	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)		582,035		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/22/2017 1:54 pm

Title XIX | 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
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.559959	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.991260	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038685	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.207191	0	0	54.00
57.00	05700	CT SCAN	0.043409	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.094857	0	0	58.00
60.00	06000	LABORATORY	0.213823	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.451041	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264120	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.167976	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.328615	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285167	0	0	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.149680	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.372506	0	0	90.00
91.00	09100	EMERGENCY	0.433025	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.861621	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/22/2017 1:54 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,425,803	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)	7,425,803	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)	7,500,061	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)	78,243	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,562,098	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,859,720	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,859,720	30.00
31.00	Primary payer payments	121	31.00
32.00	Subtotal (line 30 minus line 31)	1,859,599	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)	1,076,041	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	699,427	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	746,575	36.00
37.00	Subtotal (see instructions)	2,559,026	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)	2,559,026	40.00
40.01	Sequestration adjustment (see instructions)	51,181	40.01
41.00	Interim payments	2,693,572	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-185,727	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: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/22/2017 1:54 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		3,972,416		2,151,794	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/20/2016	29,230	12/20/2016	279,421	3.01
3.02		02/09/2017	70,842	02/09/2017	262,357	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		100,072		541,778	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)		4,072,488		2,693,572	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		235,150		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		185,727	6.02
7.00	Total Medicare program liability (see instructions)		4,307,638		2,507,845	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2017 1:54 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		551,691		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	02/09/2017	57,127		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		57,127		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)		608,818		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		77,196		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		686,014		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/22/2017 1:54 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	1,316	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,511	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	273	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4,091	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	113,458,745	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,794,482	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1350 Component CCN: 14-Z350	Period: From 07/01/2016 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 11/22/2017 1:54 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)	549,840	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)	150,174	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	470	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)	700,014	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	700,014	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)	700,014	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	700,014	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)	700,014	0	19.00
19.01	Sequestration adjustment (see instructions)	14,000	0	19.01
20.00	Interim payments	608,818	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)	77,196	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 - SWING BEDS

Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-2 | Date/Time Prepared: 11/22/2017 1:54 pm

Title XIX | 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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1350	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/22/2017 1:54 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,872,570	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)	4,872,570	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,921,296	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)	4,921,296	19.00
20.00	Deductibles (exclude professional component)	607,589	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,313,707	22.00
23.00	Coinsurance	15,904	23.00
24.00	Subtotal (line 22 minus line 23)	4,297,803	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	150,378	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	97,746	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	109,563	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,395,549	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)	4,395,549	30.00
30.01	Sequestration adjustment (see instructions)	87,911	30.01
31.00	Interim payments	4,072,488	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)	235,150	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/22/2017 1:54 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	2,275,000	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,748,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	421,000	0	0	0	7.00
8.00	Prepaid expenses	145,000	0	0	0	8.00
9.00	Other current assets	290,000	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)	9,879,000	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	99,000	0	0	0	12.00
13.00	Land improvements	1,923,000	0	0	0	13.00
14.00	Accumulated depreciation	-1,311,000	0	0	0	14.00
15.00	Buildings	11,374,000	0	0	0	15.00
16.00	Accumulated depreciation	-5,286,000	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	26,058,000	0	0	0	19.00
20.00	Accumulated depreciation	-12,479,000	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	21,751,000	0	0	0	23.00
24.00	Accumulated depreciation	-17,603,000	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	56,000	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,582,000	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	45,355,000	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	3,297,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	48,652,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	83,113,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,200,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,865,000	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	1,764,000	0	0	0	43.00
44.00	Other current liabilities	1,149,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,978,000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	8,692,000	0	0	0	46.00
47.00	Notes payable	8,846,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,897,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	21,435,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	27,413,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	55,700,000				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)	55,700,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	83,113,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/22/2017 1:54 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		34,959,894		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		16,665,876				2.00
3.00	Total (sum of line 1 and line 2)		51,625,770		0		3.00
4.00	TEMPORARILY RESTRICTED	3,012,000		0		0	4.00
5.00	PERMANENTLY RESTRICTED	1,248,000		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)		4,260,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		55,885,770		0		11.00
12.00	NET INCOME ROUNDING	1		0		0	12.00
13.00	AFS ROUNDING	185,769		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)		185,770		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		55,700,000		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	TEMPORARILY RESTRICTED		0			4.00
5.00	PERMANENTLY RESTRICTED		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	NET INCOME ROUNDING		0			12.00
13.00	AFS ROUNDING		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: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/22/2017 1:54 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,347,789		4,347,789	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	115,296		115,296	5.00
6.00	Swing bed - NF	29,192		29,192	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)	4,492,277		4,492,277	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)	4,492,277		4,492,277	17.00
18.00	Ancillary services	18,273,329	78,619,324	96,892,653	18.00
19.00	Outpatient services	1,273,745	12,586,520	13,860,265	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	47,183	194,686	241,869	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,086,534	91,400,530	115,487,064	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,884,592		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		34,884,592		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-3 | Date/Time Prepared: 11/22/2017 1:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	115,487,064	1.00
2.00	Less contractual allowances and discounts on patients' accounts	67,561,816	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,925,248	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,884,592	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,040,656	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,549,558	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	7,114	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	55	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	45,229	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	171,337	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	750,294	24.00
24.01	GRANTS	57,026	24.01
24.02	AFFILIATE COSTS	66,517	24.02
25.00	Total other income (sum of lines 6-24)	3,647,130	25.00
26.00	Total (line 5 plus line 25)	16,687,786	26.00
27.00	NON-OPERATING EXPENSES	17,995	27.00
27.01	LOSS ON DISPOSALS	3,915	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	21,910	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	16,665,876	29.00