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: 14-2009	Period: From 09/01/2016 To 08/31/2017	Worksheet S Parts I-III Date/Time Prepared: 1/29/2018 10:06 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/29/2018 Time: 10:06 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital Chicago Central (14-2009) for the cost reporting period beginning 09/01/2016 and ending 08/31/2017 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)

SR VICE PRESIDENT OF REIMBURSEMENT
Title

01/29/2018
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	-65,589	4,532	0	2,059,505	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	-65,589	4,532	0	2,059,505	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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 1/29/2018 10:05 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4058 West Melrose Street	PO Box:			1.00
2.00	City: Chicago	State: IL	Zip Code: 60641	County: COOK	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	Kindred Hospital Chicago Central	142009	16974	2	07/01/1994	N	P	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									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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2016	08/31/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 1/29/2018 10:05 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 1/29/2018 10:05 am

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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 1/29/2018 10:05 am

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

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

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 1/29/2018 10:05 am

		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)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	85,824	0	864,209	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 1/29/2018 10:05 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	189003	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: KINDRED HEALTHCARE OPERATING INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 05901	141.00
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:		142.00
143.00	City: LOUISVILLE	State: KY	Zip Code: 40202	143.00

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

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

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

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

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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
166.01							0.00	166.01
166.02							0.00	166.02
166.03							0.00	166.03

		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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-2009	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/29/2018 10:05 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 1/29/2018 10:05 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2018	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	11/30/2017	Y	11/30/2017	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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 1/29/2018 10:05 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	Y	12/31/2017	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	SIMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE OPERATING INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967945	KindredReimbursement@kindred.com	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-2009	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part II Date/Time Prepared: 1/29/2018 10:05 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 1/29/2018 10:05 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	187	68,255	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		187	68,255	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		187	68,255	0.00	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	44.00	0	0		0	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)		187				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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 1/29/2018 10:05 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	12,692	4,759	28,569			1.00
2.00	HMO and other (see instructions)	1,384	7,040				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	12,692	4,759	28,569			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	12,692	4,759	28,569	0.00	276.00	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	0	0	0	0.00	0.00	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	276.00	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	108					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 1/29/2018 10:05 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	484	165	1,071	1.00
2.00	HMO and other (see instructions)			63	274		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	484	165	1,071	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	0.00					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 WAGE INDEX INFORMATION | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part II | Date/Time Prepared: 1/29/2018 10:05 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	17,075,993	-16,855	17,059,138	574,557.90	29.69	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	35,721	35,721	762.00	46.88	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,849,354	0	2,849,354	51,754.00	55.06	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,928,506	0	1,928,506	16,816.00	114.68	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		2,314,467	0	2,314,467	54,051.00	42.82	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,605,526	0	2,605,526			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		5,540	0	5,540			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	159,802	0	159,802	3,436.99	46.49	26.00
27.00	Administrative & General	5.00	2,242,961	-16,855	2,226,106	60,512.17	36.79	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part II | Date/Time Prepared: 1/29/2018 10:05 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		14,574	0	14,574	395.00	36.90	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	179,359	0	179,359	12,680.00	14.15	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	562,182	0	562,182	39,763.00	14.14	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	562,999	0	562,999	33,270.00	16.92	34.00
35.00	Dietary under contract (see instructions)		1,871	0	1,871	98.00	19.09	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,294,145	0	1,294,145	28,978.00	44.66	38.00
39.00	Central Services and Supply	14.00	101,037	0	101,037	8,077.00	12.51	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	688,179	0	688,179	22,349.00	30.79	41.00
42.00	Social Service	17.00	716,571	-35,721	680,850	14,519.00	46.89	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 1/29/2018 10:05 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		17,092,438	-16,855	17,075,583	575,050.90	29.69	1.00
2.00	Excluded area salaries (see instructions)		0	35,721	35,721	762.00	46.88	2.00
3.00	Subtotal salaries (line 1 minus line 2)		17,092,438	-52,576	17,039,862	574,288.90	29.67	3.00
4.00	Subtotal other wages & related costs (see inst.)		7,092,327	0	7,092,327	122,621.00	57.84	4.00
5.00	Subtotal wage-related costs (see inst.)		2,605,526	0	2,605,526	0.00	15.29	5.00
6.00	Total (sum of lines 3 thru 5)		26,790,291	-52,576	26,737,715	696,909.90	38.37	6.00
7.00	Total overhead cost (see instructions)		6,523,680	-52,576	6,471,104	224,078.16	28.88	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 1/29/2018 10:05 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	15,685	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	875,865	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	2,906	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	10,493	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	62,479	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	245,872	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,208,220	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	167,951	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	16,055	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,605,526	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,849,354	2,605,526	1.00
2.00	Hospital	2,849,354	2,605,526	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		5,131,937	5,131,937	454,875	5,586,812	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,006,604	1,006,604	424,223	1,430,827	2.00
3.00	00300	OTHER CAP REL COSTS		879,098	879,098	-879,098	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	159,802	2,796,209	2,956,011	0	2,956,011	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,242,961	7,801,801	10,044,762	56,646	10,101,408	5.00
7.00	00700	OPERATION OF PLANT	179,359	2,938,015	3,117,374	-65,663	3,051,711	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	256,886	256,886	0	256,886	8.00
9.00	00900	HOUSEKEEPING	562,182	137,870	700,052	40,402	740,454	9.00
10.00	01000	DIETARY	562,999	505,607	1,068,606	1,152	1,069,758	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,294,145	40,183	1,334,328	78,861	1,413,189	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101,037	36,416	137,453	446,254	583,707	14.00
15.00	01500	PHARMACY	0	1,170,536	1,170,536	4,183	1,174,719	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	688,179	149,692	837,871	0	837,871	16.00
17.00	01700	SOCIAL SERVICE	716,571	80,564	797,135	-39,523	757,612	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,178,371	2,416,831	10,595,202	542,304	11,137,506	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	322,290	627,828	950,118	69,524	1,019,642	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	176,688	950,884	1,127,572	5,190	1,132,762	54.00
60.00	06000	LABORATORY	81,845	844,375	926,220	25,920	952,140	60.00
65.00	06500	RESPIRATORY THERAPY	1,809,564	58,473	1,868,037	305,903	2,173,940	65.00
66.00	06600	PHYSICAL THERAPY	0	1,485,028	1,485,028	14,418	1,499,446	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,756,061	1,756,061	-1,530,698	225,363	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,939,895	1,939,895	0	1,939,895	73.00
74.00	07400	RENAL DIALYSIS	0	952,264	952,264	5,394	957,658	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,075,993	33,963,057	51,039,050	-39,733	50,999,317	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	39,733	39,733	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		TOTAL (SUM OF LINES 118-199)	17,075,993	33,963,057	51,039,050	0	51,039,050	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	42,338	5,629,150		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	37,648	1,468,475		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,316	2,948,695		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-518,429	9,582,979		5.00
7.00	00700	OPERATION OF PLANT	-6,593	3,045,118		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	256,886		8.00
9.00	00900	HOUSEKEEPING	0	740,454		9.00
10.00	01000	DIETARY	-22,589	1,047,169		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,413,189		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	583,707		14.00
15.00	01500	PHARMACY	0	1,174,719		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-285	837,586		16.00
17.00	01700	SOCIAL SERVICE	0	757,612		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-255,645	10,881,861		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-131,758	887,884		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-230,978	901,784		54.00
60.00	06000	LABORATORY	0	952,140		60.00
65.00	06500	RESPIRATORY THERAPY	4,576	2,178,516		65.00
66.00	06600	PHYSICAL THERAPY	-107,609	1,391,837		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	225,363		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,939,895		73.00
74.00	07400	RENAL DIALYSIS	0	957,658		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,196,640	49,802,677		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	39,733		194.00
194.01	07951	IDLE SPACE	0	0		194.01
194.02	07952	REGIONAL OFFICE	0	0		194.02
194.03	07953	DISTRICT OFFICE	0	0		194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0		194.04
194.05	07955	REG NURSG OFFICE	0	0		194.05
194.06	07956	CONTACT CENTER	0	0		194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0		194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0		194.08
194.09	07958	VISITOR MEALS	0	0		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		194.11
200.00		TOTAL (SUM OF LINES 118-199)	-1,196,640	49,842,410		200.00

RECLASSIFICATIONS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-6 | Date/Time Prepared: 1/29/2018 10:05 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS NON ALLOWABLE CASE MANAGER				
1.00	NONALLOWABLE CLINICAL LIAISON	194.00	35,721	4,012	1.00
	TOTALS		35,721	4,012	
	B - RECLASS OXYGEN				
1.00	RESPIRATORY THERAPY	65.00	0	46,500	1.00
2.00	RESPIRATORY THERAPY	65.00	0	42,726	2.00
	TOTALS		0	89,226	
	C - RECLASS NON-CHARGEABLE MED SUPPLIES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,987	1.00
2.00	HOUSEKEEPING	9.00	0	18,263	2.00
3.00	DIETARY	10.00	0	324	3.00
4.00	NURSING ADMINISTRATION	13.00	0	58,708	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	166,700	5.00
6.00	PHARMACY	15.00	0	2,281	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	267,137	7.00
8.00	OPERATING ROOM	50.00	0	10,086	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	960	9.00
10.00	LABORATORY	60.00	0	18,310	10.00
11.00	RESPIRATORY THERAPY	65.00	0	69,698	11.00
12.00	PHYSICAL THERAPY	66.00	0	10,384	12.00
13.00	RENAL DIALYSIS	74.00	0	5,394	13.00
14.00	ADMINISTRATIVE & GENERAL	5.00	0	9,659	14.00
15.00	HOUSEKEEPING	9.00	0	22,139	15.00
16.00	DIETARY	10.00	0	828	16.00
17.00	NURSING ADMINISTRATION	13.00	0	20,153	17.00
18.00	CENTRAL SERVICES & SUPPLY	14.00	0	279,554	18.00
19.00	PHARMACY	15.00	0	1,902	19.00
20.00	SOCIAL SERVICE	17.00	0	210	20.00
21.00	ADULTS & PEDIATRICS	30.00	0	275,167	21.00
22.00	OPERATING ROOM	50.00	0	59,438	22.00
23.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,151	23.00
24.00	LABORATORY	60.00	0	7,610	24.00
25.00	RESPIRATORY THERAPY	65.00	0	84,395	25.00
26.00	PHYSICAL THERAPY	66.00	0	4,034	26.00
	TOTALS		0	1,441,472	
	D - RECLASS EQUIPMENT SERVICE CONTRACTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,079	1.00
2.00	RESPIRATORY THERAPY	65.00	0	29,674	2.00
3.00	RESPIRATORY THERAPY	65.00	0	32,910	3.00
	TOTALS		0	65,663	
	E - RECLASS VAN SERVICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,855	1.00
	TOTALS		0	16,855	
500.00	Grand Total: Increases		35,721	1,617,228	500.00

RECLASSIFICATIONS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-6 | Date/Time Prepared: 1/29/2018 10:05 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	SOCIAL SERVICE	17.00	35,721	4,012	0		1.00
	TOTALS		35,721	4,012			
	B - RECLASS OXYGEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	46,500	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	42,726	0		2.00
	TOTALS		0	89,226			
	C - RECLASS NON-CHARGEABLE MED SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	675,232	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	766,240	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
	TOTALS		0	1,441,472			
	D - RECLASS EQUIPMENT SERVICE CONTRACTS						
1.00	OPERATION OF PLANT	7.00	0	32,753	0		1.00
2.00		0.00	0	0	0		2.00
3.00	OPERATION OF PLANT	7.00	0	32,910	0		3.00
	TOTALS		0	65,663			
	E - RECLASS VAN SERVICE						
1.00	ADMINISTRATIVE & GENERAL	5.00	16,855	0	0		1.00
	TOTALS		16,855	0			
500.00	Grand Total: Decreases		52,576	1,600,373			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 1/29/2018 10:05 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	69,408	0	0	0	0	3.00
4.00	Building Improvements	11,223,353	437,479	0	437,479	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,621,259	318,538	0	318,538	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	21,914,020	756,017	0	756,017	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	21,914,020	756,017	0	756,017	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	69,408	0	3.00
4.00	Building Improvements	11,660,832	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	10,939,797	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,670,037	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	22,670,037	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	572,929	4,559,008	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	346,427	660,177	0	0	0	2.00
3.00	Total (sum of lines 1-2)	919,356	5,219,185	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	5,131,937		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,006,604		2.00
3.00	Total (sum of lines 1-2)	0	6,138,541		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part III | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	11,730,241	0	11,730,241	0.517434	46,414	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,939,796	0	10,939,796	0.482566	43,287	2.00
3.00	Total (sum of lines 1-2)	22,670,037	0	22,670,037	1.000000	89,701	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	408,461	0	454,875	645,419	4,559,008	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	380,936	0	424,223	384,075	660,177	2.00
3.00	Total (sum of lines 1-2)	789,397	0	879,098	1,029,494	5,219,185	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	16,262	408,461	0	5,629,150	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	43,287	380,936	0	1,468,475	2.00
3.00	Total (sum of lines 1-2)	0	59,549	789,397	0	7,097,625	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8 | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-7,832	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-37,119	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,043	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	-611,263			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	1,390,274			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-22,589	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		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	B	-2,827	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-9,375	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8 | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02			0		0.00	0	33.02
33.03			0		0.00	0	33.03
33.04			0		0.00	0	33.04
33.05	OCCUPATIONAL INCENTIVE INCOME	A	-8,720	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PATIENT PERSONAL SERVICES EXPENSE	A	-7	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PROFESSIONAL FEES - CAPITAL PROJECT	A	-1,891	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	A	-1,115,200	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09			0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	A	-162,699	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	A	-150	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	A	-999	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER OPERATING - MARKETING	A	-131,667	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER OPERATING - INTEREST	A	-470	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15			0		0.00	0	33.15
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33.18			0		0.00	0	33.18
33.19			0		0.00	0	33.19
33.20	OTHER OPERATING - TRADE SHOW BOOTH	A	-600	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21			0		0.00	0	33.21
33.22			0		0.00	0	33.22
33.23	CHARITABLE CONTRIBUTIONS	A	-22,480	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24			0		0.00	0	33.24
33.25	OTHER OPERATING - PENALTIES OTHER	A	-795	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26			0		0.00	0	33.26
33.27			0		0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	A	-122,749	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	CABLE TV AND SATELLITE	A	-33,002	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30			0		0.00	0	33.30
33.31			0		0.00	0	33.31
33.32	RENT - OTHER	A	101,663	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33			0		0.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	A	-372,825	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35			0		0.00	0	33.35
33.36			0		0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	A	-6,063	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38			0		0.00	0	33.38
33.39			0		0.00	0	33.39
33.40			0		0.00	0	33.40
33.41			0		0.00	0	33.41
33.42			0		0.00	0	33.42
33.43	DISTRICT OFFICE SALES AND MARKETING	A	-50,312	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	DISTRICT OFC SALES AND MKT BENEFITS	A	-4,555	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	BUSINESS INTERRUPTIONS INS PREMIUM	A	-30,152	CAP REL COSTS-BLDG & FIXT	1.00	12	33.45
34.00	MEDICARE VS BOOK BLDG	A	60,582	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	A	-120,879	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02			0		0.00	0	34.02
34.03	ASSET ADD-ON BLDG	A	11,908	CAP REL COSTS-BLDG & FIXT	1.00	9	34.03
34.04	ASSET ADD-ON MOV EQUIP	A	164,402	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.04
34.05			0		0.00	0	34.05
34.06			0		0.00	0	34.06
34.07			0		0.00	0	34.07
34.08	NON ALLOWABLE LOBBYING FEES	A	-16,165	ADMINISTRATIVE & GENERAL	5.00	0	34.08
34.09			0		0.00	0	34.09
34.10			0		0.00	0	34.10
34.11			0		0.00	0	34.11
34.12			0		0.00	0	34.12
34.13	PATIENT PHONE - DEPREC EQUIP	A	-5,875	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.13
34.14			0		0.00	0	34.14

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8 | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.15			0		0.00	0	34.15
34.16			0		0.00	0	34.16
34.17			0		0.00	0	34.17
34.18			0		0.00	0	34.18
34.19			0		0.00	0	34.19
34.20			0		0.00	0	34.20
34.21			0		0.00	0	34.21
34.22			0		0.00	0	34.22
34.23			0		0.00	0	34.23
34.24			0		0.00	0	34.24
34.25	VAN SERVICE VEHICLE MAINTENANCE	A	-4,550	OPERATION OF PLANT	7.00	0	34.25
34.26	VAN SERVICE EE BENEFITS	A	-2,761	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.26
34.27	VAN SERVICE SALARY	A	-16,855	ADMINISTRATIVE & GENERAL	5.00	0	34.27
34.28			0		0.00	0	34.28
35.00			0		0.00	0	35.00
35.01			0		0.00	0	35.01
35.02			0		0.00	0	35.02
35.03			0		0.00	0	35.03
35.04			0		0.00	0	35.04
35.05			0		0.00	0	35.05
35.06			0		0.00	0	35.06
35.07			0		0.00	0	35.07
35.08			0		0.00	0	35.08
35.09	PHYSICIAN FEE ADJUSTMENT	A	4,125	MEDICAL RECORDS & LIBRARY	16.00	0	35.09
35.10			0		0.00	0	35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	-47,281	ADULTS & PEDIATRICS	30.00	0	35.11
35.12			0		0.00	0	35.12
35.13			0		0.00	0	35.13
35.14			0		0.00	0	35.14
35.15	PHYSICIAN FEE ADJUSTMENT	A	35,325	RADIOLOGY-DIAGNOSTIC	54.00	0	35.15
35.16			0		0.00	0	35.16
35.17	PHYSICIAN FEE ADJUSTMENT	A	7,831	RESPIRATORY THERAPY	65.00	0	35.17
35.18			0		0.00	0	35.18
35.19			0		0.00	0	35.19
35.20			0		0.00	0	35.20
35.21			0		0.00	0	35.21
35.22			0		0.00	0	35.22
35.23			0		0.00	0	35.23
35.24			0		0.00	0	35.24
35.25			0		0.00	0	35.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,196,640				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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 1/29/2018 10:05 am

	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	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	3,733,010	2,235,127	1.00
2.00	0.00			0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	210,310	210,310	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	973,465	973,465	4.00
4.01	66.00	PHYSICAL THERAPY	Therapy Services	1,376,070	1,483,679	4.01
4.03	50.00	OPERATING ROOM	HOSPITAL RELATED SERVICES	263,564	263,564	4.03
4.21	54.00	RADIOLOGY-DIAGNOSTIC	Hospital Related services	518,683	518,683	4.21
4.22	60.00	LABORATORY	Hospital Related services	540,137	540,137	4.22
5.00	0		0	7,615,239	6,224,965	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	KHOI	100.00	Admin & Gen	100.00	6.00
7.00	B	KHOI	100.00	Cornerstone	100.00	7.00
8.00	B	KHOI	100.00	Cornerstone	100.00	8.00
9.00	B	KHOI	100.00	RehabCare	100.00	9.00
10.00	B	KHOI	100.00	KH - Chicago N.	100.00	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: 14-2009	Period: From 09/01/2016 To 08/31/2017	Worksheet A-8-1 Date/Time Prepared: 1/29/2018 10:05 am

	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	1,497,883	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-107,609	0		4.01
4.03	0	0		4.03
4.21	0	0		4.21
4.22	0	0		4.22
5.00	1,390,274			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	HomeOffice Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00	Therapy Svcs		9.00
10.00	Hospital		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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 1/29/2018 10:05 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	853,534	0	853,534	211,500	7,621	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	DR. C	11,664	11,664	0	211,500	0	3.00
4.00	54.00	DR. D	107,700	107,700	0	271,900	0	4.00
5.00	54.00	DR. E	8,850	0	8,850	271,900	30	5.00
6.00	16.00	DR. F	4,125	0	4,125	211,500	25	6.00
7.00	50.00	DR. G	4,704	4,704	0	246,400	0	7.00
8.00	50.00	DR. H	61,175	61,175	0	239,400	0	8.00
9.00	30.00	DR. I	803	803	0	211,500	0	9.00
10.00	30.00	DR. J	945,419	0	945,419	211,500	8,441	10.00
12.00	65.00	DR. L	7,831	0	7,831	211,500	45	12.00
13.00	30.00	DR. M	11,664	11,664	0	211,500	0	13.00
14.00	30.00	DR. N	12,251	0	12,251	211,500	90	14.00
15.00	30.00	DR. O	25,663	0	25,663	211,500	166	15.00
16.00	54.00	DR. P	147,750	147,750	0	271,900	0	16.00
17.00	54.00	DR. Q	10,500	0	10,500	271,900	35	17.00
18.00	30.00	DR. R	4,725	4,725	0	211,500	0	18.00
19.00	50.00	DR. S	4,704	4,704	0	246,400	0	19.00
20.00	50.00	DR. T	61,175	61,175	0	239,400	0	20.00
21.00	30.00	DR. U	1,899	1,899	0	211,500	0	21.00
200.00			2,286,136	417,963	1,868,173		16,453	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	30.00	DR. A	774,924	38,746	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	54.00	DR. D	0	0	0	0	0	4.00
5.00	54.00	DR. E	3,922	196	0	0	0	5.00
6.00	16.00	DR. F	2,542	127	0	0	0	6.00
7.00	50.00	DR. G	0	0	0	0	0	7.00
8.00	50.00	DR. H	0	0	0	0	0	8.00
9.00	30.00	DR. I	0	0	0	0	0	9.00
10.00	30.00	DR. J	858,304	42,915	0	0	0	10.00
12.00	65.00	DR. L	4,576	229	0	0	0	12.00
13.00	30.00	DR. M	0	0	0	0	0	13.00
14.00	30.00	DR. N	9,151	458	0	0	0	14.00
15.00	30.00	DR. O	16,879	844	0	0	0	15.00
16.00	54.00	DR. P	0	0	0	0	0	16.00
17.00	54.00	DR. Q	4,575	229	0	0	0	17.00
18.00	30.00	DR. R	0	0	0	0	0	18.00
19.00	50.00	DR. S	0	0	0	0	0	19.00
20.00	50.00	DR. T	0	0	0	0	0	20.00
21.00	30.00	DR. U	0	0	0	0	0	21.00
200.00			1,674,873	83,744	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	30.00	DR. A	0	774,924	78,610	78,610		1.00
2.00	0.00		0	0	0	0		2.00
3.00	30.00	DR. C	0	0	0	11,664		3.00
4.00	54.00	DR. D	0	0	0	107,700		4.00
5.00	54.00	DR. E	0	3,922	4,928	4,928		5.00
6.00	16.00	DR. F	0	2,542	1,583	1,583		6.00
7.00	50.00	DR. G	0	0	0	4,704		7.00
8.00	50.00	DR. H	0	0	0	61,175		8.00
9.00	30.00	DR. I	0	0	0	803		9.00
10.00	30.00	DR. J	0	858,304	87,115	87,115		10.00
12.00	65.00	DR. L	0	4,576	3,255	3,255		12.00
13.00	30.00	DR. M	0	0	0	11,664		13.00
14.00	30.00	DR. N	0	9,151	3,100	3,100		14.00
15.00	30.00	DR. O	0	16,879	8,784	8,784		15.00
16.00	54.00	DR. P	0	0	0	147,750		16.00
17.00	54.00	DR. Q	0	4,575	5,925	5,925		17.00
18.00	30.00	DR. R	0	0	0	4,725		18.00
19.00	50.00	DR. S	0	0	0	4,704		19.00
20.00	50.00	DR. T	0	0	0	61,175		20.00
21.00	30.00	DR. U	0	0	0	1,899		21.00
200.00			0	1,674,873	193,300	611,263		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,629,150	5,629,150				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,468,475		1,468,475			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,948,695	0	0	2,948,695		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,582,979	580,375	165,597	388,424	10,717,375	5.00
7.00	00700	OPERATION OF PLANT	3,045,118	866,461	247,226	31,296	4,190,101	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	256,886	32,533	9,283	0	298,702	8.00
9.00	00900	HOUSEKEEPING	740,454	124,599	35,552	98,093	998,698	9.00
10.00	01000	DIETARY	1,047,169	291,816	83,263	98,235	1,520,483	10.00
11.00	01100	CAFETERIA	0	74,838	21,353	0	96,191	11.00
13.00	01300	NURSING ADMINISTRATION	1,413,189	89,554	25,552	225,810	1,754,105	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	583,707	201,006	57,353	17,630	859,696	14.00
15.00	01500	PHARMACY	1,174,719	106,233	30,311	0	1,311,263	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	837,586	56,354	16,079	120,078	1,030,097	16.00
17.00	01700	SOCIAL SERVICE	757,612	51,213	14,613	118,799	942,237	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,881,861	1,944,209	554,740	1,427,007	14,807,817	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	887,884	322,622	92,053	56,235	1,358,794	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	901,784	125,658	35,854	30,830	1,094,126	54.00
60.00	06000	LABORATORY	952,140	19,347	5,520	14,281	991,288	60.00
65.00	06500	RESPIRATORY THERAPY	2,178,516	117,966	33,659	315,744	2,645,885	65.00
66.00	06600	PHYSICAL THERAPY	1,391,837	128,248	36,593	0	1,556,678	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	225,363	0	0	0	225,363	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,939,895	0	0	0	1,939,895	73.00
74.00	07400	RENAL DIALYSIS	957,658	7,927	2,262	0	967,847	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,802,677	5,140,959	1,466,863	2,942,462	49,306,641	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,651	1,612	0	7,263	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	39,733	0	0	6,233	45,966	194.00
194.01	07951	IDLE SPACE	0	482,540	0	0	482,540	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
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)	49,842,410	5,629,150	1,468,475	2,948,695	49,842,410	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,717,375					5.00
7.00	00700	OPERATION OF PLANT	1,147,778	5,337,879				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,822	46,937	427,461			8.00
9.00	00900	HOUSEKEEPING	273,569	179,766	0	1,452,033		9.00
10.00	01000	DIETARY	416,500	421,020	0	119,607	2,477,610	10.00
11.00	01100	CAFETERIA	26,349	107,973	0	30,674	603,629	11.00
13.00	01300	NURSING ADMINISTRATION	480,495	129,205	0	36,706	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	235,493	290,003	0	82,387	0	14.00
15.00	01500	PHARMACY	359,189	153,268	0	43,542	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	282,170	81,305	0	23,098	0	16.00
17.00	01700	SOCIAL SERVICE	258,103	73,888	0	20,991	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,056,256	2,805,023	427,461	796,879	1,728,405	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	372,209	465,466	0	132,234	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	299,710	181,294	0	51,504	0	54.00
60.00	06000	LABORATORY	271,540	27,913	0	7,930	0	60.00
65.00	06500	RESPIRATORY THERAPY	724,777	170,197	0	48,351	0	65.00
66.00	06600	PHYSICAL THERAPY	426,415	185,031	0	52,565	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,733	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	531,388	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	265,118	11,437	0	3,249	0	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,570,614	5,329,726	427,461	1,449,717	2,332,034	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,990	8,153	0	2,316	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	12,591	0	0	0	0	194.00
194.01	07951	IDLE SPACE	132,180	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	145,576	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	10,717,375	5,337,879	427,461	1,452,033	2,477,610	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	864,816					11.00
13.00	01300	NURSING ADMINISTRATION	59,350	2,459,861				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,957	0	1,484,536			14.00
15.00	01500	PHARMACY	0	0	17,926	1,885,188		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,632	0	634	0	1,463,936	16.00
17.00	01700	SOCIAL SERVICE	29,675	0	286	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	559,587	2,387,512	770,116	26,133	714,495	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,957	72,349	106,618	0	15,056	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,479	0	4,111	0	75,727	54.00
60.00	06000	LABORATORY	12,718	0	36,156	1,189	119,426	60.00
65.00	06500	RESPIRATORY THERAPY	114,461	0	214,046	0	196,586	65.00
66.00	06600	PHYSICAL THERAPY	0	0	20,749	18	49,852	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	306,389	0	14,275	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,857,848	249,464	73.00
74.00	07400	RENAL DIALYSIS	0	0	7,505	0	29,055	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	864,816	2,459,861	1,484,536	1,885,188	1,463,936	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
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)	864,816	2,459,861	1,484,536	1,885,188	1,463,936	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,325,180					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,325,180	30,404,864	0	30,404,864		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,539,683	0	2,539,683		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,714,951	0	1,714,951		54.00
60.00	06000	LABORATORY	0	1,468,160	0	1,468,160		60.00
65.00	06500	RESPIRATORY THERAPY	0	4,114,303	0	4,114,303		65.00
66.00	06600	PHYSICAL THERAPY	0	2,291,308	0	2,291,308		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	607,760	0	607,760		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,578,595	0	4,578,595		73.00
74.00	07400	RENAL DIALYSIS	0	1,284,211	0	1,284,211		74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,325,180	49,003,835	0	49,003,835		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,722	0	19,722		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	58,557	0	58,557		194.00
194.01	07951	IDLE SPACE	0	614,720	0	614,720		194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0		194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0		194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0		194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0		194.05
194.06	07956	CONTACT CENTER	0	0	0	0		194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0		194.08
194.09	07958	VISITOR MEALS	0	145,576	0	145,576		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194.11
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,325,180	49,842,410	0	49,842,410		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	351,781	580,375	165,597	1,097,753	0	5.00
7.00	00700	OPERATION OF PLANT	0	866,461	247,226	1,113,687	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,533	9,283	41,816	0	8.00
9.00	00900	HOUSEKEEPING	0	124,599	35,552	160,151	0	9.00
10.00	01000	DIETARY	0	291,816	83,263	375,079	0	10.00
11.00	01100	CAFETERIA	0	74,838	21,353	96,191	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	89,554	25,552	115,106	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	201,006	57,353	258,359	0	14.00
15.00	01500	PHARMACY	0	106,233	30,311	136,544	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56,354	16,079	72,433	0	16.00
17.00	01700	SOCIAL SERVICE	0	51,213	14,613	65,826	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,944,209	554,740	2,498,949	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	322,622	92,053	414,675	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	125,658	35,854	161,512	0	54.00
60.00	06000	LABORATORY	0	19,347	5,520	24,867	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	117,966	33,659	151,625	0	65.00
66.00	06600	PHYSICAL THERAPY	0	128,248	36,593	164,841	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	7,927	2,262	10,189	0	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	351,781	5,140,959	1,466,863	6,959,603	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,651	1,612	7,263	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	482,540	0	482,540	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
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)	351,781	5,629,150	1,468,475	7,449,406	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,097,753					5.00
7.00	00700	OPERATION OF PLANT	117,566	1,231,253				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,381	10,827	61,024			8.00
9.00	00900	HOUSEKEEPING	28,021	41,465	0	229,637		9.00
10.00	01000	DIETARY	42,662	97,114	0	18,916	533,771	10.00
11.00	01100	CAFETERIA	2,699	24,905	0	4,851	130,045	11.00
13.00	01300	NURSING ADMINISTRATION	49,217	29,803	0	5,805	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,121	66,893	0	13,029	0	14.00
15.00	01500	PHARMACY	36,791	35,353	0	6,886	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,902	18,754	0	3,653	0	16.00
17.00	01700	SOCIAL SERVICE	26,437	17,043	0	3,320	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	415,461	647,016	61,024	126,025	372,363	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,125	107,366	0	20,913	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,699	41,818	0	8,145	0	54.00
60.00	06000	LABORATORY	27,814	6,439	0	1,254	0	60.00
65.00	06500	RESPIRATORY THERAPY	74,238	39,258	0	7,647	0	65.00
66.00	06600	PHYSICAL THERAPY	43,677	42,680	0	8,313	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,323	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,430	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	27,156	2,638	0	514	0	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,082,720	1,229,372	61,024	229,271	502,408	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	204	1,881	0	366	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	1,290	0	0	0	0	194.00
194.01	07951	IDLE SPACE	13,539	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	31,363	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
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)	1,097,753	1,231,253	61,024	229,637	533,771	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	258,691					11.00
13.00	01300	NURSING ADMINISTRATION	17,753	217,684				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,072	0	367,474			14.00
15.00	01500	PHARMACY	0	0	4,437	220,011		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,949	0	157	0	137,848	16.00
17.00	01700	SOCIAL SERVICE	8,877	0	71	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	167,389	211,282	190,629	3,050	67,265	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,072	6,402	26,392	0	1,418	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,536	0	1,018	0	7,132	54.00
60.00	06000	LABORATORY	3,804	0	8,950	139	11,248	60.00
65.00	06500	RESPIRATORY THERAPY	34,239	0	52,984	0	18,515	65.00
66.00	06600	PHYSICAL THERAPY	0	0	5,136	2	4,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	75,842	0	1,344	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	216,820	23,495	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,858	0	2,736	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	258,691	217,684	367,474	220,011	137,848	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
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)	258,691	217,684	367,474	220,011	137,848	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	121,574					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	121,574	4,882,027	0	4,882,027		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	620,363	0	620,363		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	252,860	0	252,860		54.00
60.00	06000	LABORATORY	0	84,515	0	84,515		60.00
65.00	06500	RESPIRATORY THERAPY	0	378,506	0	378,506		65.00
66.00	06600	PHYSICAL THERAPY	0	269,344	0	269,344		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	83,509	0	83,509		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	294,745	0	294,745		73.00
74.00	07400	RENAL DIALYSIS	0	45,091	0	45,091		74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	121,574	6,910,960	0	6,910,960		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,714	0	9,714		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	1,290	0	1,290		194.00
194.01	07951	IDLE SPACE	0	496,079	0	496,079		194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0		194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0		194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0		194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0		194.05
194.06	07956	CONTACT CENTER	0	0	0	0		194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0		194.08
194.09	07958	VISITOR MEALS	0	31,363	0	31,363		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194.11
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	121,574	7,449,406	0	7,449,406		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	143,441					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		131,145				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	16,899,336			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,789	14,789	2,226,106	-10,717,375	39,125,035	5.00
7.00	00700	OPERATION OF PLANT	22,079	22,079	179,359	0	4,190,101	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	829	829	0	0	298,702	8.00
9.00	00900	HOUSEKEEPING	3,175	3,175	562,182	0	998,698	9.00
10.00	01000	DIETARY	7,436	7,436	562,999	0	1,520,483	10.00
11.00	01100	CAFETERIA	1,907	1,907	0	0	96,191	11.00
13.00	01300	NURSING ADMINISTRATION	2,282	2,282	1,294,145	0	1,754,105	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,122	5,122	101,037	0	859,696	14.00
15.00	01500	PHARMACY	2,707	2,707	0	0	1,311,263	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,436	1,436	688,179	0	1,030,097	16.00
17.00	01700	SOCIAL SERVICE	1,305	1,305	680,850	0	942,237	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,542	49,542	8,178,371	0	14,807,817	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,221	8,221	322,290	0	1,358,794	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,202	3,202	176,688	0	1,094,126	54.00
60.00	06000	LABORATORY	493	493	81,845	0	991,288	60.00
65.00	06500	RESPIRATORY THERAPY	3,006	3,006	1,809,564	0	2,645,885	65.00
66.00	06600	PHYSICAL THERAPY	3,268	3,268	0	0	1,556,678	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	225,363	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,939,895	73.00
74.00	07400	RENAL DIALYSIS	202	202	0	0	967,847	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	131,001	131,001	16,863,615	-10,717,375	38,589,266	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144	144	0	0	7,263	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	35,721	0	45,966	194.00
194.01	07951	IDLE SPACE	12,296	0	0	0	482,540	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
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)	5,629,150	1,468,475	2,948,695		10,717,375	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.243661	11.197339	0.174486		0.273926	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		1,097,753	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.028058	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	94,277					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	829	28,569				8.00
9.00	00900	HOUSEKEEPING	3,175	0	90,273			9.00
10.00	01000	DIETARY	7,436	0	7,436	129,075		10.00
11.00	01100	CAFETERIA	1,907	0	1,907	31,447	204	11.00
13.00	01300	NURSING ADMINISTRATION	2,282	0	2,282	0	14	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,122	0	5,122	0	4	14.00
15.00	01500	PHARMACY	2,707	0	2,707	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,436	0	1,436	0	11	16.00
17.00	01700	SOCIAL SERVICE	1,305	0	1,305	0	7	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,542	28,569	49,542	90,044	132	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,221	0	8,221	0	4	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,202	0	3,202	0	2	54.00
60.00	06000	LABORATORY	493	0	493	0	3	60.00
65.00	06500	RESPIRATORY THERAPY	3,006	0	3,006	0	27	65.00
66.00	06600	PHYSICAL THERAPY	3,268	0	3,268	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	202	0	202	0	0	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	94,133	28,569	90,129	121,491	204	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144	0	144	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	7,584	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
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)	5,337,879	427,461	1,452,033	2,477,610	864,816	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	56.619101	14.962407	16.084909	19.195119	4,239.294118	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,231,253	61,024	229,637	533,771	258,691	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.059951	2.136022	2.543806	4.135355	1,268.093137	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/29/2018 10:05 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	136					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,091,940				14.00
15.00	01500	PHARMACY	0	13,185	1,968,443			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	466	0	182,387,734		16.00
17.00	01700	SOCIAL SERVICE	0	210	0	0	28,569	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	132	566,455	27,287	89,022,710	28,569	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4	78,422	0	1,875,714	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,024	0	9,433,997	0	54.00
60.00	06000	LABORATORY	0	26,594	1,242	14,877,992	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	157,440	0	24,490,622	0	65.00
66.00	06600	PHYSICAL THERAPY	0	15,262	19	6,210,565	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	225,362	0	1,778,325	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,939,895	31,078,153	0	73.00
74.00	07400	RENAL DIALYSIS	0	5,520	0	3,619,656	0	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	136	1,091,940	1,968,443	182,387,734	28,569	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,459,861	1,484,536	1,885,188	1,463,936	1,325,180	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18,087.213235	1.359540	0.957705	0.008027	46.385243	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	217,684	367,474	220,011	137,848	121,574	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,600.617647	0.336533	0.111769	0.000756	4.255452	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,404,864		30,404,864	177,609	30,582,473	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,539,683		2,539,683	0	2,539,683	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,714,951		1,714,951	10,853	1,725,804	54.00
60.00	06000	LABORATORY	1,468,160		1,468,160	0	1,468,160	60.00
65.00	06500	RESPIRATORY THERAPY	4,114,303	0	4,114,303	3,255	4,117,558	65.00
66.00	06600	PHYSICAL THERAPY	2,291,308	0	2,291,308	0	2,291,308	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	607,760		607,760	0	607,760	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,578,595		4,578,595	0	4,578,595	73.00
74.00	07400	RENAL DIALYSIS	1,284,211		1,284,211	0	1,284,211	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00		Subtotal (see instructions)	49,003,835	0	49,003,835	191,717	49,195,552	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	49,003,835	0	49,003,835	191,717	49,195,552	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	89,022,710		89,022,710			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,875,714	0	1,875,714	1.353982	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,433,997	0	9,433,997	0.181784	0.000000	54.00
60.00	06000	LABORATORY	14,877,992	0	14,877,992	0.098680	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	24,490,622	0	24,490,622	0.167995	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,210,565	0	6,210,565	0.368937	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,778,325	0	1,778,325	0.341760	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,078,153	0	31,078,153	0.147325	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,619,656	0	3,619,656	0.354788	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	182,387,734	0	182,387,734			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	182,387,734	0	182,387,734			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	1.353982
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182935
60.00	06000	LABORATORY	0.098680
65.00	06500	RESPIRATORY THERAPY	0.168128
66.00	06600	PHYSICAL THERAPY	0.368937
67.00	06700	OCCUPATIONAL THERAPY	0.000000
68.00	06800	SPEECH PATHOLOGY	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341760
73.00	07300	DRUGS CHARGED TO PATIENTS	0.147325
74.00	07400	RENAL DIALYSIS	0.354788
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
91.00	09100	EMERGENCY	0.000000
		OTHER REIMBURSABLE COST CENTERS	
95.00	09500	AMBULANCE SERVICES	0.000000
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 10:05 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,404,864		30,404,864	177,609	30,582,473	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,539,683		2,539,683	0	2,539,683	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,714,951		1,714,951	10,853	1,725,804	54.00
60.00	06000	LABORATORY	1,468,160		1,468,160	0	1,468,160	60.00
65.00	06500	RESPIRATORY THERAPY	4,114,303	0	4,114,303	3,255	4,117,558	65.00
66.00	06600	PHYSICAL THERAPY	2,291,308	0	2,291,308	0	2,291,308	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	607,760		607,760	0	607,760	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,578,595		4,578,595	0	4,578,595	73.00
74.00	07400	RENAL DIALYSIS	1,284,211		1,284,211	0	1,284,211	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00		Subtotal (see instructions)	49,003,835	0	49,003,835	191,717	49,195,552	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	49,003,835	0	49,003,835	191,717	49,195,552	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 10:05 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	89,022,710		89,022,710			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,875,714	0	1,875,714	1.353982	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,433,997	0	9,433,997	0.181784	0.000000	54.00
60.00	06000	LABORATORY	14,877,992	0	14,877,992	0.098680	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	24,490,622	0	24,490,622	0.167995	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,210,565	0	6,210,565	0.368937	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,778,325	0	1,778,325	0.341760	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,078,153	0	31,078,153	0.147325	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,619,656	0	3,619,656	0.354788	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	182,387,734	0	182,387,734			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	182,387,734	0	182,387,734			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 10:05 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part I Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,882,027	0	4,882,027	28,569	170.89	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	4,882,027		4,882,027	28,569		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	12,692	2,168,936	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	12,692	2,168,936	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part II Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	620,363	1,875,714	0.330734	867,479	286,905	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	252,860	9,433,997	0.026803	3,988,007	106,891	54.00
60.00	06000	LABORATORY	84,515	14,877,992	0.005681	6,892,986	39,159	60.00
65.00	06500	RESPIRATORY THERAPY	378,506	24,490,622	0.015455	9,636,682	148,935	65.00
66.00	06600	PHYSICAL THERAPY	269,344	6,210,565	0.043369	2,763,704	119,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,509	1,778,325	0.046959	741,777	34,833	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	294,745	31,078,153	0.009484	13,332,476	126,445	73.00
74.00	07400	RENAL DIALYSIS	45,091	3,619,656	0.012457	1,411,625	17,585	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	2,028,933	93,365,024		39,634,736	880,612	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part III Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,569	0.00	12,692	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	28,569		12,692	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		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	1,875,714	0.000000	0.000000	867,479	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,433,997	0.000000	0.000000	3,988,007	54.00
60.00	06000	LABORATORY	0	14,877,992	0.000000	0.000000	6,892,986	60.00
65.00	06500	RESPIRATORY THERAPY	0	24,490,622	0.000000	0.000000	9,636,682	65.00
66.00	06600	PHYSICAL THERAPY	0	6,210,565	0.000000	0.000000	2,763,704	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,778,325	0.000000	0.000000	741,777	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,078,153	0.000000	0.000000	13,332,476	73.00
74.00	07400	RENAL DIALYSIS	0	3,619,656	0.000000	0.000000	1,411,625	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	0	93,365,024			39,634,736	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.353982	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.181784	0	664,342	0	0	54.00
60.00	06000	LABORATORY	0.098680	0	5,047	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.167995	0	206,324	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.368937	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341760	0	11,380	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.147325	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.354788	0	205,920	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	1,093,013	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	1,093,013	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,767	0		54.00
60.00	06000	LABORATORY	498	0		60.00
65.00	06500	RESPIRATORY THERAPY	34,661	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,889	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	73,058	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	232,873	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	232,873	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-2009	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/29/2018 10:05 am
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,569	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,569	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.	782	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	27,787	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	12,692	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	300	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	30,582,473	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	30,582,473	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	89,022,710	28.00
29.00	Private room charges (excluding swing-bed charges)	2,410,124	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	86,612,586	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.343536	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	3,082.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	3,117.02	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)	30,582,473	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)	1,070.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,586,532	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)	13,586,532	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,942,671	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	21,529,203	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)	2,168,936	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	880,612	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,049,548	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	18,479,655	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,882,027	30,582,473	0.159635	0	0	90.00
91.00	Nursing School cost	0	30,582,473	0.000000	0	0	91.00
92.00	Allied health cost	0	30,582,473	0.000000	0	0	92.00
93.00	All other Medical Education	0	30,582,473	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-2009	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/29/2018 10:05 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,569	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,569	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)	28,569	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,759	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	30,404,864	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	30,404,864	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)	30,404,864	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)	1,064.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,064,813	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)	5,064,813	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/29/2018 10:05 am

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,558,489	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,623,302	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/29/2018 10:05 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,882,027	30,404,864	0.160567	0	0	90.00
91.00	Nursing School cost	0	30,404,864	0.000000	0	0	91.00
92.00	Allied health cost	0	30,404,864	0.000000	0	0	92.00
93.00	All other Medical Education	0	30,404,864	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-2 | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered	0.00	0				1.00
	Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	0.00	0	28,569	0.00	0	2.00
3.00	INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)	0.00	0				9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)	0.00	0				20.00

	Cost Center Description			Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V	
		1.00	2.00	3.00	4.00	5.00	
	Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0.00	0	0	0.000000	0	23.00
24.00	EMERGENCY	0.00	0	0	0.000000	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)	0.00	0				27.00
28.00	Total (sum of lines 20 and 27)	0.00	0				28.00

	Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
	Hospital Inpatient Routine Services:						
29.00	ADULTS & PEDIATRICS	0	0	0	28,569	0.00	29.00
30.00	Swing Bed - SNF		0	0	0	0.00	30.00
31.00	Swing Bed - NF		0				31.00
32.00	INTENSIVE CARE UNIT	0		0	0	0.00	32.00
33.00	CORONARY CARE UNIT						33.00
34.00	BURN INTENSIVE CARE UNIT						34.00
35.00	SURGICAL INTENSIVE CARE UNIT						35.00
36.00	OTHER SPECIAL CARE (SPECIFY)						36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)	0		0			37.00
38.00	SUBPROVIDER - IPF						38.00
39.00	SUBPROVIDER - IRF						39.00
40.00	SUBPROVIDER						40.00
41.00	SKILLED NURSING FACILITY	0		0	0	0.00	41.00
42.00	Total (sum of lines 37 through 41)	0		0			42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-2 | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	Not In Approved Teaching Program (from Part I:)	Not In Approved Teaching Program Amount	In Approved Teaching Program (from Part II, col. 7, -)	
		1.00	2.00	3.00	
	PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)				
	Hospital				
43.00	Inpatient	col. 9, line 9.00	0	line 37.00	43.00
44.00	Outpatient	col. 9, line 27.00	0		44.00
45.00	Total Hospital (sum of lines 43 and 44)		0		45.00
46.00	SUBPROVIDER - IPF				46.00
47.00	SUBPROVIDER - IRF				47.00
48.00	SUBPROVIDER				48.00
49.00	SKILLED NURSING FACILITY	col. 9, line 13.00	0	col. 9, line 41.00	49.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-2 | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	Health Care Program Inpatient Days: Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Health Care Program Inpatient Days: Title XIX	Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
		6.00	7.00	8.00	9.00	10.00	
	PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered						1.00
	Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	12,692	4,759	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)						20.00

	Cost Center Description	Titles V and XIX Outpatient and Title XVIII Part B Charges: Title XVIII Part B	Titles V and XIX Outpatient and Title XVIII Part B Charges: Title XIX	Titles V and XIX Outpatient and Title XVIII Part B Cost: Title V	Titles V and XIX Outpatient and Title XVIII Part B Cost: Title XVIII Part B	Titles V and XIX Outpatient and Title XVIII Part B Cost: Title XIX	
		6.00	7.00	8.00	9.00	10.00	
	Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	0	27.00
28.00	Total (sum of lines 20 and 27)						28.00

	Cost Center Description	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents		
		6.00	7.00	11.00		
	PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)					
	Hospital Inpatient Routine Services:					
29.00	ADULTS & PEDIATRICS	0	0	0		29.00
30.00	Swing Bed - SNF	0	0			30.00
31.00	Swing Bed - NF					31.00
32.00	INTENSIVE CARE UNIT	0	0	0		32.00
33.00	CORONARY CARE UNIT					33.00
34.00	BURN INTENSIVE CARE UNIT					34.00
35.00	SURGICAL INTENSIVE CARE UNIT					35.00
36.00	OTHER SPECIAL CARE (SPECIFY)					36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)		0	0		37.00
38.00	SUBPROVIDER - IPF					38.00
39.00	SUBPROVIDER - IRF					39.00
40.00	SUBPROVIDER					40.00
41.00	SKILLED NURSING FACILITY	0	0	0		41.00
42.00	Total (sum of lines 37 through 41)		0	0		42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-2 | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	In Approved Teaching Program Amount	Total Title XVIII Costs (to Wkst. E, Part B -)	Total Title XVIII Costs (col. 2 + col. 4)		
		4.00	5.00	6.00		
	PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
	Hospital					
43.00	Inpatient	0		0		43.00
44.00	Outpatient					44.00
45.00	Total Hospital (sum of lines 43 and 44)	0	line 22	0		45.00
46.00	SUBPROVIDER - IPF					46.00
47.00	SUBPROVIDER - IRF					47.00
48.00	SUBPROVIDER					48.00
49.00	SKILLED NURSING FACILITY	0	line 22	0		49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-3 | Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		39,620,030		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.353982	867,479	1,174,551	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182935	3,988,007	729,546	54.00
60.00	06000	LABORATORY	0.098680	6,892,986	680,200	60.00
65.00	06500	RESPIRATORY THERAPY	0.168128	9,636,682	1,620,196	65.00
66.00	06600	PHYSICAL THERAPY	0.368937	2,763,704	1,019,633	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341760	741,777	253,510	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.147325	13,332,476	1,964,207	73.00
74.00	07400	RENAL DIALYSIS	0.354788	1,411,625	500,828	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		39,634,736	7,942,671	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)		39,634,736		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-3 | Date/Time Prepared: 1/29/2018 10:05 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		14,782,821		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.353982	195,015	264,047	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.181784	870,919	158,319	54.00
60.00	06000	LABORATORY	0.098680	1,520,380	150,031	60.00
65.00	06500	RESPIRATORY THERAPY	0.167995	4,318,644	725,511	65.00
66.00	06600	PHYSICAL THERAPY	0.368937	795,888	293,633	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341760	345,854	118,199	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.147325	5,065,963	746,343	73.00
74.00	07400	RENAL DIALYSIS	0.354788	288,640	102,406	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,401,303	2,558,489	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)		13,401,303		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-2009	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part B Date/Time Prepared: 1/29/2018 10:05 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	232,873	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)	232,873	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,093,013	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)	1,093,013	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)	1,093,013	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	860,140	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)	232,873	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)	218,603	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	14,270	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)	14,270	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	14,270	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	14,270	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)	14,270	40.00
40.01	Sequestration adjustment (see instructions)	285	40.01
41.00	Interim payments	9,453	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	4,532	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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 1/29/2018 10:05 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		17,104,639		9,453	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	12/05/2016	281,100		0	3.01
3.02		11/30/2017	1,665,700		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)		1,946,800		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)		19,051,439		9,453	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		4,532	6.01
6.02	SETTLEMENT TO PROGRAM		65,589		0	6.02
7.00	Total Medicare program liability (see instructions)		18,985,850		13,985	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	Provider CCN: 14-2009	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part IV Date/Time Prepared: 1/29/2018 10:05 am
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	18,845,170	1.00
1.01	Full standard payment amount	15,453,944	1.01
1.02	Short stay outlier standard payment amount	2,132,883	1.02
1.03	Site neutral payment amount - Cost	112,970	1.03
1.04	Site neutral payment amount - IPPS comparable	1,145,373	1.04
2.00	Outlier Payments	1,480,630	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	20,325,800	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	20,325,800	7.00
8.00	Primary payer payments	0	8.00
9.00	Subtotal (line 7 less line 8).	20,325,800	9.00
10.00	Deductibles	30,044	10.00
11.00	Subtotal (line 9 minus line 10)	20,295,756	11.00
12.00	Coinsurance	1,653,099	12.00
13.00	Subtotal (line 11 minus line 12)	18,642,657	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,124,090	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	730,659	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	980,047	16.00
17.00	Subtotal (sum of lines 13 and 15)	19,373,316	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.99	Recovery of Accelerated Depreciation	0	21.99
22.00	Total amount payable to the provider (see instructions)	19,373,316	22.00
22.01	Sequestration adjustment (see instructions)	387,466	22.01
23.00	Interim payments	19,051,439	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)	-65,589	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)	1,480,630	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-2009	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 1/29/2018 10:05 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	7,623,302		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	7,623,302	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	7,623,302	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	14,782,821		8.00
9.00	Ancillary service charges	13,401,303	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	28,184,124	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	28,184,124	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	20,560,822	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	7,623,302	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	7,623,302	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	7,623,302	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	7,623,302	0	36.00
37.00	OTHER ADJUSTMENTS	0	0	37.00
37.01	OTHER ADJUSTMENTS	0	0	37.01
38.00	Subtotal (line 36 ± line 37)	7,623,302	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	7,623,302	0	40.00
41.00	Interim payments	5,563,797	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	2,059,505	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G | Date/Time Prepared: 1/29/2018 10:05 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,422,534	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,219,296	0	0	0	4.00
5.00	Other receivable	56,380	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,309,060	0	0	0	6.00
7.00	Inventory	431,317	0	0	0	7.00
8.00	Prepaid expenses	124,523	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,944,990	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	231,365	0	0	0	15.00
16.00	Accumulated depreciation	-227,269	0	0	0	16.00
17.00	Leasehold improvements	11,498,875	0	0	0	17.00
18.00	Accumulated depreciation	-10,495,475	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,939,797	0	0	0	23.00
24.00	Accumulated depreciation	-9,334,658	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,612,635	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	310,421	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	310,421	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,868,046	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,301,298	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,083,438	0	0	0	38.00
39.00	Payroll taxes payable	6,077	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,779,287	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,170,100	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-8,565,600	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-8,565,600	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-4,395,500	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	21,263,546				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)	21,263,546	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,868,046	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G-1 | Date/Time Prepared: 1/29/2018 10:05 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		28,413,168		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-7,149,631				2.00
3.00	Total (sum of line 1 and line 2)		21,263,537		0		3.00
4.00	Additions (credit adjustments)	0		0		0	4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	9		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)		9		0		10.00
11.00	Subtotal (line 3 plus line 10)		21,263,546		0		11.00
12.00	Deductions (debit adjustments)	0		0		0	12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		21,263,546		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)		0			4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)		0			12.00
13.00	INTERCOMPANY TRANSFERS\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: 14-2009 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 1/29/2018 10:05 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	89,022,710		89,022,710	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	89,022,710		89,022,710	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	89,022,710		89,022,710	17.00
18.00	Ancillary services	93,365,024	0	93,365,024	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	182,387,734	0	182,387,734	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		51,039,050		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)		51,039,050		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-2009	Period: From 09/01/2016 To 08/31/2017	Worksheet G-3 Date/Time Prepared: 1/29/2018 10:05 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	182,387,734	1.00
2.00	Less contractual allowances and discounts on patients' accounts	138,611,848	2.00
3.00	Net patient revenues (line 1 minus line 2)	43,775,886	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	51,039,050	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,263,164	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	7,832	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	22,589	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	2,827	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	80,285	24.00
25.00	Total other income (sum of lines 6-24)	113,533	25.00
26.00	Total (line 5 plus line 25)	-7,149,631	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-7,149,631	29.00