

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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet S Parts I-III Date/Time Prepared: 1/26/2018 2:26 pm
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 1/26/2018 Time: 2:26 pm

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 Peoria (14-2013) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	68,935	0	0	22,190	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
200.00 Total	0	68,935	0	0	22,190	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: 14-2013		Period: From 09/01/2016 To 08/31/2017		Worksheet S-2 Part I Date/Time Prepared: 1/26/2018 2:25 pm					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL Zip Code: 61605		4.00 County: PEORIA					
1.00 Street: 500 West Romeo B Garrett Ave.		2.00 City: Peoria									
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
3.00 Hospital and Hospital-Based Component Identification:											
3.00	Hospital	Kindred Hospital Peoria	142013	37900	2	05/01/2010	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:	To:				
						1.00	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		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
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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/26/2018 2:25 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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	XVII	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

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	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		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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				
64.00	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. 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	

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		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
				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

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		V	XIX			
		1.00	2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00	
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				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:	3,809	0	39,213		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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/26/2018 2:25 pm
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		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	N			161.00
						1.00		
Multi campus								
165.00	Is this hospital part of a Multi campus 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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/26/2018 2:25 pm
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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. 1, 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2013		Period: From 09/01/2016 To 08/31/2017		Worksheet S-2 Part II Date/Time Prepared: 1/26/2018 2:25 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
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				
		1.00	2.00				
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					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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part II Date/Time Prepared: 1/26/2018 2:25 pm		
		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N	21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved 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: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-2
Part II
Date/Time Prepared:
1/26/2018 2:25 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2018 2:25 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	50	18,250	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)		50	18,250	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)		50	18,250	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)		50			0	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: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2018 2:25 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,952	20	8,074			1.00
2.00 HMO and other (see instructions)	757	1,451				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,952	20	8,074			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)	4,952	20	8,074	0.00	81.80	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	81.80	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	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2018 2:25 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	195	1	335	1.00
2.00 HMO and other (see instructions)				30	57		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		195	1	335	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: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part II
Date/Time Prepared:
1/26/2018 2:25 pm

	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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	5,354,198	0	5,354,198	170,264.13	31.45
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	124,306	124,306	2,823.00	44.03
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,308,061	0	1,308,061	20,518.00	63.75
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		295,565	0	295,565	1,296.00	228.06
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		747,779	0	747,779	17,464.00	42.82
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		992,116	0	992,116		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		23,581	0	23,581		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related		0	0	0		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	50,689	0	50,689	1,013.27	50.03
27.00	Administrative & General	5.00	1,212,412	0	1,212,412	23,835.13	50.87

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part II
Date/Time Prepared:
1/26/2018 2:25 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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.)	7,580	0	7,580	158.00	47.97	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	104,747	0	104,747	9,869.00	10.61	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	168,518	0	168,518	11,104.00	15.18	34.00
35.00	Dietary under contract (see instructions)	84,999	0	84,999	1,428.00	59.52	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	582,829	0	582,829	14,798.00	39.39	38.00
39.00	Central Services and Supply	36,929	0	36,929	2,755.00	13.40	39.00
40.00	Pharmacy	308,605	0	308,605	7,013.00	44.00	40.00
41.00	Medical Records & Medical Records Library	207,348	0	207,348	7,449.00	27.84	41.00
42.00	Social Service	372,917	-124,306	248,611	5,647.00	44.03	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet S-3
Part III
Date/Time Prepared:
1/26/2018 2:25 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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)	5,446,777	0	5,446,777	171,850.13	31.69	1.00
2.00	Excluded area salaries (see instructions)	0	124,306	124,306	2,823.00	44.03	2.00
3.00	Subtotal salaries (line 1 minus line 2)	5,446,777	-124,306	5,322,471	169,027.13	31.49	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,351,405	0	2,351,405	39,278.00	59.87	4.00
5.00	Subtotal wage-related costs (see inst.)	992,116	0	992,116	0.00	18.64	5.00
6.00	Total (sum of lines 3 thru 5)	8,790,298	-124,306	8,665,992	208,305.13	41.60	6.00
7.00	Total overhead cost (see instructions)	3,137,573	-124,306	3,013,267	85,069.40	35.42	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 1/26/2018 2:25 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			2,200 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)		230,195	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		779	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		2,947	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)		10,112	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		291,624	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		361,498	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		88,371	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		4,392	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		992,118	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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet S-3 Part V Date/Time Prepared: 1/26/2018 2:25 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,308,061	992,116	1.00
2.00	Hospital	1,308,061	992,116	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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet A Date/Time Prepared: 1/26/2018 2:25 pm		
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (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		2,036,070	2,036,070	97,172	2,133,242	1.00
2.00	00200		256,399	256,399	446,736	703,135	2.00
3.00	00300		543,908	543,908	-543,908	0	3.00
4.00	00400	50,689	1,091,326	1,142,015	0	1,142,015	4.00
5.00	00500	1,212,412	1,127,425	2,339,837	19,124	2,358,961	5.00
7.00	00700	0	611,413	611,413	-13,182	598,231	7.00
8.00	00800	0	66,354	66,354	0	66,354	8.00
9.00	00900	104,747	8,929	113,676	0	113,676	9.00
10.00	01000	168,518	223,210	391,728	1,161	392,889	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	582,829	2,135	584,964	385	585,349	13.00
14.00	01400	36,929	-33,509	3,420	51,634	55,054	14.00
15.00	01500	308,605	12,511	321,116	2,843	323,959	15.00
16.00	01600	207,348	24,616	231,964	0	231,964	16.00
17.00	01700	372,917	31,054	403,971	-134,657	269,314	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,589,536	1,680,713	3,270,249	260,169	3,530,418	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	60,179	112,384	172,563	0	172,563	50.00
54.00	05400	108,208	10,943	119,151	3,949	123,100	54.00
60.00	06000	0	205,537	205,537	1,418	206,955	60.00
65.00	06500	551,281	9,114	560,395	59,495	619,890	65.00
66.00	06600	0	337,724	337,724	780	338,504	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	486,589	486,589	-387,776	98,813	71.00
73.00	07300	0	716,200	716,200	0	716,200	73.00
74.00	07400	0	273,424	273,424	0	273,424	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		5,354,198	9,834,469	15,188,667	-134,657	15,054,010	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	134,657	134,657	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00		5,354,198	9,834,469	15,188,667	0	15,188,667	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet A
Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,687	2,130,555	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-15,203	687,932	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,667	1,140,348	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	910,774	3,269,735	5.00
7.00	00700	OPERATION OF PLANT	-577	597,654	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,354	8.00
9.00	00900	HOUSEKEEPING	0	113,676	9.00
10.00	01000	DIETARY	-19,657	373,232	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	585,349	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,026	92,080	14.00
15.00	01500	PHARMACY	0	323,959	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-716	231,248	16.00
17.00	01700	SOCIAL SERVICE	0	269,314	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-191,992	3,338,426	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	0	172,563	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-120	122,980	54.00
60.00	06000	LABORATORY	0	206,955	60.00
65.00	06500	RESPIRATORY THERAPY	0	619,890	65.00
66.00	06600	PHYSICAL THERAPY	0	338,504	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	98,813	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	716,200	73.00
74.00	07400	RENAL DIALYSIS	0	273,424	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)	715,181	15,769,191	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	134,657	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 ADMINISTRATIONS 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)	715,181	15,903,848	200.00

RECLASSIFICATIONS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-6

Date/Time Prepared:
1/26/2018 2:25 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	NONALLOWABLE CLINICAL	194.00	124,306	10,351	1.00	
	LIASON					
	TOTALS		124,306	10,351		
B - RECLASS OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	37,694	1.00	
	TOTALS		0	37,694		
C - RECLASS NON-CHARGEABLE MED SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,124	1.00	
2.00	DIETARY	10.00	0	1,161	2.00	
3.00	NURSING ADMINISTRATION	13.00	0	385	3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	51,634	4.00	
5.00	PHARMACY	15.00	0	2,843	5.00	
6.00	ADULTS & PEDIATRICS	30.00	0	260,169	6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	491	7.00	
8.00	LABORATORY	60.00	0	1,418	8.00	
9.00	RESPIRATORY THERAPY	65.00	0	12,077	9.00	
10.00	PHYSICAL THERAPY	66.00	0	780	10.00	
	TOTALS		0	350,082		
D - RECLASS EQUIPMENT SERVICE CONTRACTS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,458	1.00	
2.00	RESPIRATORY THERAPY	65.00	0	9,724	2.00	
	TOTALS		0	13,182		
500.00	Grand Total: Increases		124,306	411,309	500.00	

RECLASSIFICATIONS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-6

Date/Time Prepared:
1/26/2018 2:25 pm

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	124,306	10,351	0	1.00
	TOTALS		124,306	10,351		
B - RECLASS OXYGEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	37,694	0	1.00
	TOTALS		0	37,694		
C - RECLASS NON-CHARGEABLE MED SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	350,082	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
	TOTALS		0	350,082		
D - RECLASS EQUIPMENT SERVICE CONTRACTS						
1.00	OPERATION OF PLANT	7.00	0	13,182	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	13,182		
500.00	Grand Total: Decreases		124,306	411,309		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-7
Part I
Date/Time Prepared:
1/26/2018 2:25 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	197,980	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	832,852	77,336	0	77,336	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,030,832	77,336	0	77,336	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,030,832	77,336	0	77,336	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	0	0			3.00
4.00	Building Improvements	197,980	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	910,188	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	1,108,168	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	1,108,168	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-7
Part II
Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	16,633	2,019,437	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	78,176	178,223	0	0	0	2.00
3.00	Total (sum of lines 1-2)	94,809	2,197,660	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	2,036,070				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	256,399				2.00
3.00	Total (sum of lines 1-2)	0	2,292,469				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-7
Part III
Date/Time Prepared:
1/26/2018 2:25 pm

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	197,980	0	197,980	0.178655	4,332	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	910,188	0	910,188	0.821345	19,915	2.00
3.00	Total (sum of lines 1-2)	1,108,168	0	1,108,168	1.000000	24,247	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	92,840	0	97,172	22,190	2,019,437	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	426,821	0	446,736	62,973	178,223	2.00
3.00	Total (sum of lines 1-2)	519,661	0	543,908	85,163	2,197,660	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	-3,912	92,840	0	2,130,555	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	19,915	426,821	0	687,932	2.00
3.00	Total (sum of lines 1-2)	0	16,003	519,661	0	2,818,487	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-8

Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-1,020		ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-1,690		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	-1,468		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-577		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	-191,994				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	1,206,095				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-19,657		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	-716		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	-6,238		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-8

Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.02 RADIOLOGY COPY FEES	B	-120	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03		0		0.00	0	33.03
33.04		0		0.00	0	33.04
33.05		0		0.00	0	33.05
33.06		0		0.00	0	33.06
33.07		0		0.00	0	33.07
33.08 MEDICARE BAD DEBT - PART A	A	-137,012	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09		0		0.00	0	33.09
33.10 OTHER MEDICARE NON ALLOWABLE	A	-3,476	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11		0		0.00	0	33.11
33.12 OTHER OPERATING - PUBLIC RELATIONS	A	-1,995	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 OTHER OPERATING - MARKETING	A	-46,407	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14 OTHER OPERATING - INTEREST	A	-49	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		0		0.00	0	33.20
33.21		0		0.00	0	33.21
33.22		0		0.00	0	33.22
33.23 CHARITABLE CONTRIBUTIONS	A	-7,500	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24		0		0.00	0	33.24
33.25		0		0.00	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	-1,940	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29 CABLE TV AND SATELLITE	A	-5,231	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30 VENDING MACHINE	A	1,226	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31		0		0.00	0	33.31
33.32		0		0.00	0	33.32
33.33		0		0.00	0	33.33
33.34 MALPRACTICE TAIL LIABILITY	A	-14,867	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	-46,521	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	-16,388	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44 DISTRICT OFC SALES AND MKT BENEFITS	A	-1,667	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45 BUSINESS INTERRUPTIONS INS PREMIUM	A	-8,244	CAP REL COSTS-BLDG & FIXT	1.00	12	33.45
34.00 MEDICARE VS BOOK BLDG	A	5,557	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01 MEDICARE VS BOOK MOV EQUIP	A	-47,053	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02		0		0.00	0	34.02
34.03		0		0.00	0	34.03
34.04 ASSET ADD-ON MOV EQUIP	A	31,850	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.04
34.05		0		0.00	0	34.05
34.06 MSA MGMT FEE REV ADD-BACK	A	495,741	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07 MSA MGMT FEE EXP OFFSET	A	-495,591	ADMINISTRATIVE & GENERAL	5.00	0	34.07
34.08 NON ALLOWABLE LOBBYING FEES	A	-4,895	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		0		0.00	0	34.13
34.14		0		0.00	0	34.14
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

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		3.00
34.20		0			0	34.20
34.21		0			0	34.21
34.22		0			0	34.22
34.23		0			0	34.23
34.24		0			0	34.24
34.25	Contract Fee Offset	A	37,026	CENTRAL SERVICES & SUPPLY	14.00	0 34.25
34.26			0		0.00	0 34.26
34.27			0		0.00	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			0		0.00	0 35.09
35.10			0		0.00	0 35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	2	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			0		0.00	0 35.15
35.16			0		0.00	0 35.16
35.17			0		0.00	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.)		715,181			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: 14-2013 Period: From 09/01/2016 To 08/31/2017 Worksheet A-8-1

Date/Time Prepared: 1/26/2018 2:25 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	1,206,095	0
2.00	0.00			0	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	254,727	254,727
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	44,204	44,204
4.22	60.00	LABORATORY	Hospital Related services	204,134	204,134
5.00	0			1,709,160	503,065

* 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.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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	KH01	51.00	Admin & Gen	51.00	6.00
7.00	B	KH01	100.00	Cornerstone	100.00	7.00
8.00	B	KH01	100.00	Cornerstone	100.00	8.00
9.00			0.00		0.00	9.00
10.00	B		49.00	Methodist M.C.	49.00	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: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-8-1

Date/Time Prepared:
1/26/2018 2:25 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,206,095	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.22	0	0		4.22
5.00	1,206,095			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	Home Office Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00			9.00
10.00	Hospital /JV		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: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet A-8-2

Date/Time Prepared:
1/26/2018 2:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	267,662	0	267,662	211,500	1,139	1.00
2.00	30.00	DR. B	1,073	0	1,073	211,500	7	2.00
3.00	30.00	DR. C	37,533	37,533	0	211,500	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	30.00	DR. E	3,780	0	3,780	211,500	21	5.00
6.00	30.00	DR. F	610	610	0	211,500	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			310,658	38,143	272,515		1,167	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	115,817	5,791	0	0	0	1.00
2.00	30.00	DR. B	712	36	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	30.00	DR. E	2,135	107	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			118,664	5,934	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	115,817	151,845	151,845	1.00
2.00	30.00	DR. B	0	712	361	361	2.00
3.00	30.00	DR. C	0	0	0	37,533	3.00
4.00	0.00		0	0	0	0	4.00
5.00	30.00	DR. E	0	2,135	1,645	1,645	5.00
6.00	30.00	DR. F	0	0	0	610	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	118,664	153,851	191,994	200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet B Part I Date/Time Prepared: 1/26/2018 2:25 pm
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,130,555	2,130,555			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	687,932		687,932		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,140,348	10,890	3,516	1,154,754	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,269,735	87,120	28,130	263,983	3,648,968
7.00 00700	OPERATION OF PLANT	597,654	245,782	79,360	0	922,796
8.00 00800	LAUNDRY & LINEN SERVICE	66,354	0	0	0	66,354
9.00 00900	HOUSEKEEPING	113,676	33,729	10,891	22,807	181,103
10.00 01000	DIETARY	373,232	122,816	39,656	36,692	572,396
11.00 01100	CAFETERIA	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	585,349	18,453	5,958	126,902	736,662
14.00 01400	CENTRAL SERVICES & SUPPLY	92,080	56,719	18,314	8,041	175,154
15.00 01500	PHARMACY	323,959	30,061	9,706	67,194	430,920
16.00 01600	MEDICAL RECORDS & LIBRARY	231,248	30,817	9,951	45,147	317,163
17.00 01700	SOCIAL SERVICE	269,314	22,309	7,203	54,131	352,957
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,338,426	1,016,217	328,125	346,094	5,028,862
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	172,563	0	0	13,103	185,666
54.00 05400	RADIOLOGY-DIAGNOSTIC	122,980	37,283	12,038	23,561	195,862
60.00 06000	LABORATORY	206,955	9,226	2,979	0	219,160
65.00 06500	RESPIRATORY THERAPY	619,890	18,339	5,922	120,033	764,184
66.00 06600	PHYSICAL THERAPY	338,504	390,794	126,183	0	855,481
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	98,813	0	0	0	98,813
73.00 07300	DRUGS CHARGED TO PATIENTS	716,200	0	0	0	716,200
74.00 07400	RENAL DIALYSIS	273,424	0	0	0	273,424
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	15,769,191	2,130,555	687,932	1,127,688	15,742,125
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	NONALLOWABLE CLINICAL LIAISON	134,657	0	0	27,066	161,723
194.01 07951	IDLE SPACE	0	0	0	0	0
194.02 07952	REGIONAL OFFICE	0	0	0	0	0
194.03 07953	DISTRICT OFFICE	0	0	0	0	0
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05 07955	REG NURSG OFFICE	0	0	0	0	0
194.06 07956	CONTACT CENTER	0	0	0	0	0
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	0
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09 07958	VISITOR MEALS	0	0	0	0	0
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118-201)	15,903,848	2,130,555	687,932	1,154,754	15,903,848

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet B
Part I
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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	3,648,968				5.00	
7.00	00700	OPERATION OF PLANT	274,768	1,197,564			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	19,757	0	86,111		8.00	
9.00	00900	HOUSEKEEPING	53,925	22,607	0	257,635	9.00	
10.00	01000	DIETARY	170,434	82,316	0	18,050	10.00	
11.00	01100	CAFETERIA	0	0	0	295,690	11.00	
13.00	01300	NURSING ADMINISTRATION	219,346	12,368	0	2,712	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	52,153	38,015	0	8,336	14.00	
15.00	01500	PHARMACY	128,309	20,148	0	4,418	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	94,437	20,655	0	4,529	16.00	
17.00	01700	SOCIAL SERVICE	105,095	14,953	0	3,279	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,497,378	681,110	86,111	149,348	523,062	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	55,283	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,319	24,989	0	5,479	0	54.00
60.00	06000	LABORATORY	65,256	6,184	0	1,356	0	60.00
65.00	06500	RESPIRATORY THERAPY	227,540	12,292	0	2,695	0	65.00
66.00	06600	PHYSICAL THERAPY	254,725	261,927	0	57,433	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	29,422	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	213,253	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	81,414	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	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)	3,600,814	1,197,564	86,111	257,635	818,752	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	48,154	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	24,444	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)	3,648,968	1,197,564	86,111	257,635	843,196	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet B Part I Date/Time Prepared: 1/26/2018 2:25 pm
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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	295,690					11.00
13.00	01300	34,497	1,005,585				13.00
14.00	01400	4,928	0	278,586			14.00
15.00	01500	14,785	0	2,722	601,302		15.00
16.00	01600	19,713	0	0	0	456,497	16.00
17.00	01700	19,713	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	147,844	973,147	192,292	0	231,866	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,928	32,438	0	0	2,520	50.00
54.00	05400	4,928	0	352	0	12,509	54.00
60.00	06000	0	0	1,004	0	26,530	60.00
65.00	06500	44,354	0	10,918	0	69,901	65.00
66.00	06600	0	0	1,355	0	14,882	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	69,943	0	5,433	71.00
73.00	07300	0	0	0	601,302	84,164	73.00
74.00	07400	0	0	0	0	8,692	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		295,690	1,005,585	278,586	601,302	456,497	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		295,690	1,005,585	278,586	601,302	456,497	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

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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	495,997			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	495,997	10,007,017	0	10,007,017
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	280,835	0	280,835
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	302,438	0	302,438
60.00	06000	LABORATORY	0	319,490	0	319,490
65.00	06500	RESPIRATORY THERAPY	0	1,131,884	0	1,131,884
66.00	06600	PHYSICAL THERAPY	0	1,445,803	0	1,445,803
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	203,611	0	203,611
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,614,919	0	1,614,919
74.00	07400	RENAL DIALYSIS	0	363,530	0	363,530
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	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	495,997	15,669,527	0	15,669,527
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	209,877	0	209,877
194.01	07951	IDLE SPACE	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	24,444	0	24,444
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	495,997	15,903,848	0	15,903,848

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

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Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	10,890	3,516	14,406	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	113,528	87,120	28,130	228,778	5.00
7.00 00700	OPERATION OF PLANT	0	245,782	79,360	325,142	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	33,729	10,891	44,620	9.00
10.00 01000	DIETARY	0	122,816	39,656	162,472	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	18,453	5,958	24,411	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	56,719	18,314	75,033	14.00
15.00 01500	PHARMACY	0	30,061	9,706	39,767	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	30,817	9,951	40,768	16.00
17.00 01700	SOCIAL SERVICE	0	22,309	7,203	29,512	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,016,217	328,125	1,344,342	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	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	37,283	12,038	49,321	54.00
60.00 06000	LABORATORY	0	9,226	2,979	12,205	60.00
65.00 06500	RESPIRATORY THERAPY	0	18,339	5,922	24,261	65.00
66.00 06600	PHYSICAL THERAPY	0	390,794	126,183	516,977	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	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	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)	113,528	2,130,555	687,932	2,932,015	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	194.00
194.01 07951	IDLE SPACE	0	0	0	0	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	0	0	0	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	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	113,528	2,130,555	687,932	2,932,015	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet B Part II Date/Time Prepared: 1/26/2018 2:25 pm			
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	232,071				5.00
7.00	00700	OPERATION OF PLANT	17,475	342,617			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,257	0	1,257		8.00
9.00	00900	HOUSEKEEPING	3,430	6,468	0	54,802	9.00
10.00	01000	DIETARY	10,839	23,550	0	3,839	10.00
11.00	01100	CAFETERIA	0	0	0	70,542	11.00
13.00	01300	NURSING ADMINISTRATION	13,950	3,538	0	577	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,317	10,876	0	1,773	14.00
15.00	01500	PHARMACY	8,160	5,764	0	940	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,006	5,909	0	963	16.00
17.00	01700	SOCIAL SERVICE	6,684	4,278	0	697	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	95,232	194,863	1,257	31,769	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	3,516	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,709	7,149	0	1,166	54.00
60.00	06000	LABORATORY	4,150	1,769	0	288	60.00
65.00	06500	RESPIRATORY THERAPY	14,471	3,517	0	573	65.00
66.00	06600	PHYSICAL THERAPY	16,200	74,936	0	12,217	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	1,871	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,563	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,178	0	0	0	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)	229,008	342,617	1,257	54,802	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	3,063	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	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	0	0	5,832	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					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	232,071	342,617	1,257	54,802	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-2013		Period: From 09/01/2016 To 08/31/2017		Worksheet B Part II Date/Time Prepared: 1/26/2018 2:25 pm	
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	70,542					11.00
13.00	01300	NURSING ADMINISTRATION	8,230	52,289				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,176	0	92,275			14.00
15.00	01500	PHARMACY	3,527	0	901	59,897		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,703	0	0	0	58,912	16.00
17.00	01700	SOCIAL SERVICE	4,703	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,270	50,602	63,693	0	29,917	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	1,176	1,687	0	0	325	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,176	0	117	0	1,615	54.00
60.00	06000	LABORATORY	0	0	332	0	3,424	60.00
65.00	06500	RESPIRATORY THERAPY	10,581	0	3,616	0	9,023	65.00
66.00	06600	PHYSICAL THERAPY	0	0	449	0	1,921	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	23,167	0	701	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,897	10,864	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,122	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)	70,542	52,289	92,275	59,897	58,912	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 ADMINISTRATIONS 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)	70,542	52,289	92,275	59,897	58,912	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet B Part II Date/Time Prepared: 1/26/2018 2:25 pm			
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	46,549			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	46,549	2,022,598	0	2,022,598	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	6,867	0	6,867	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	64,547	0	64,547	54.00
60.00	06000	LABORATORY	0	22,168	0	22,168	60.00
65.00	06500	RESPIRATORY THERAPY	0	67,539	0	67,539	65.00
66.00	06600	PHYSICAL THERAPY	0	622,700	0	622,700	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	25,739	0	25,739	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	84,324	0	84,324	73.00
74.00	07400	RENAL DIALYSIS	0	6,300	0	6,300	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)	46,549	2,922,782	0	2,922,782	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	3,401	0	3,401	194.00
194.01	07951	IDLE SPACE	0	0	0	0	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 ADMINISTRATIONS 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	5,832	0	5,832	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	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	46,549	2,932,015	0	2,932,015	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet B-1

Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	56,345				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		56,345			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	288	288	5,303,509		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,304	2,304	1,212,412	-3,648,968	12,254,880
7.00 00700	OPERATION OF PLANT	6,500	6,500	0	0	922,796
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	66,354
9.00 00900	HOUSEKEEPING	892	892	104,747	0	181,103
10.00 01000	DIETARY	3,248	3,248	168,518	0	572,396
11.00 01100	CAFETERIA	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	488	488	582,829	0	736,662
14.00 01400	CENTRAL SERVICES & SUPPLY	1,500	1,500	36,929	0	175,154
15.00 01500	PHARMACY	795	795	308,605	0	430,920
16.00 01600	MEDICAL RECORDS & LIBRARY	815	815	207,348	0	317,163
17.00 01700	SOCIAL SERVICE	590	590	248,611	0	352,957
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	26,875	26,875	1,589,536	0	5,028,862
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	60,179	0	185,666
54.00 05400	RADIOLOGY-DIAGNOSTIC	986	986	108,208	0	195,862
60.00 06000	LABORATORY	244	244	0	0	219,160
65.00 06500	RESPIRATORY THERAPY	485	485	551,281	0	764,184
66.00 06600	PHYSICAL THERAPY	10,335	10,335	0	0	855,481
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	98,813
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	716,200
74.00 07400	RENAL DIALYSIS	0	0	0	0	273,424
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	56,345	56,345	5,179,203	-3,648,968	12,093,157
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	124,306	0	161,723
194.01 07951	IDLE SPACE	0	0	0	0	0
194.02 07952	REGIONAL OFFICE	0	0	0	0	0
194.03 07953	DISTRICT OFFICE	0	0	0	0	0
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05 07955	REG NURSG OFFICE	0	0	0	0	0
194.06 07956	CONTACT CENTER	0	0	0	0	0
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	0
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09 07958	VISITOR MEALS	0	0	0	0	0
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
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)	2,130,555	687,932	1,154,754		3,648,968
203.00	Unit cost multiplier (Wkst. B, Part I)	37.812672	12.209282	0.217734		0.297756
204.00	Cost to be allocated (per Wkst. B, Part II)			14,406		232,071
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002716		0.018937

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet B-1

Date/Time Prepared:
1/26/2018 2:25 pm

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	47,253				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,074			8.00
9.00	00900	HOUSEKEEPING	892	0	46,361		9.00
10.00	01000	DIETARY	3,248	0	3,248	22,870	10.00
11.00	01100	CAFETERIA	0	0	0	8,020	60 11.00
13.00	01300	NURSING ADMINISTRATION	488	0	488	0	7 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,500	0	1,500	0	1 14.00
15.00	01500	PHARMACY	795	0	795	0	3 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	815	0	815	0	4 16.00
17.00	01700	SOCIAL SERVICE	590	0	590	0	4 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,875	8,074	26,875	14,187	30 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	0	0	0	1 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986	0	986	0	1 54.00
60.00	06000	LABORATORY	244	0	244	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	485	0	485	0	9 65.00
66.00	06600	PHYSICAL THERAPY	10,335	0	10,335	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	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)	47,253	8,074	46,361	22,207	60 118.00
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	663	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)	1,197,564	86,111	257,635	843,196	295,690 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.343661	10.665222	5.557149	36.869086	4,928.166667 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	342,617	1,257	54,802	201,158	70,542 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.250693	0.155685	1.182071	8.795715	1,175.700000 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet B-1
Date/Time Prepared:
1/26/2018 2:25 pm

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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	31					13.00
14.00	01400	0	393,582				14.00
15.00	01500	0	3,845	716,200			15.00
16.00	01600	0	0	0	52,797,241		16.00
17.00	01700	0	0	0	0	8,074	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	30	271,667	0	26,816,197	8,074	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1	0	0	291,515	0	50.00
54.00	05400	0	498	0	1,446,846	0	54.00
60.00	06000	0	1,418	0	3,068,509	0	60.00
65.00	06500	0	15,425	0	8,084,795	0	65.00
66.00	06600	0	1,914	0	1,721,309	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	98,815	0	628,332	0	71.00
73.00	07300	0	0	716,200	9,734,468	0	73.00
74.00	07400	0	0	0	1,005,270	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		31	393,582	716,200	52,797,241	8,074	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00		1,005,585	278,586	601,302	456,497	495,997	202.00
203.00		32,438.225806	0.707822	0.839573	0.008646	61.431385	203.00
204.00		52,289	92,275	59,897	58,912	46,549	204.00
205.00		1,686.741935	0.234449	0.083632	0.001116	5.765296	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet C
Part I
Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE	Total Costs	
					Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	10,007,017		10,007,017	153,851	10,160,868	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	280,835		280,835	0	280,835	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	302,438		302,438	0	302,438	54.00
60.00	06000 LABORATORY	319,490		319,490	0	319,490	60.00
65.00	06500 RESPIRATORY THERAPY	1,131,884	0	1,131,884	0	1,131,884	65.00
66.00	06600 PHYSICAL THERAPY	1,445,803	0	1,445,803	0	1,445,803	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	203,611		203,611	0	203,611	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,614,919		1,614,919	0	1,614,919	73.00
74.00	07400 RENAL DIALYSIS	363,530		363,530	0	363,530	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)	15,669,527	0	15,669,527	153,851	15,823,378	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	15,669,527	0	15,669,527	153,851	15,823,378	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet C
Part I
Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,816,197		26,816,197		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	291,515	0	291,515	0.963364	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,446,846	0	1,446,846	0.209033	54.00
60.00	06000	LABORATORY	3,068,509	0	3,068,509	0.104119	60.00
65.00	06500	RESPIRATORY THERAPY	8,084,795	0	8,084,795	0.140002	65.00
66.00	06600	PHYSICAL THERAPY	1,721,309	0	1,721,309	0.839944	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	628,332	0	628,332	0.324050	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,734,468	0	9,734,468	0.165897	73.00
74.00	07400	RENAL DIALYSIS	1,005,270	0	1,005,270	0.361624	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	52,797,241	0	52,797,241		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	52,797,241	0	52,797,241		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet C Part I Date/Time Prepared: 1/26/2018 2:25 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.963364		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.209033		54.00
60.00	06000 LABORATORY	0.104119		60.00
65.00	06500 RESPIRATORY THERAPY	0.140002		65.00
66.00	06600 PHYSICAL THERAPY	0.839944		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	0.324050		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.165897		73.00
74.00	07400 RENAL DIALYSIS	0.361624		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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet C
Part I
Date/Time Prepared:
1/26/2018 2:25 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	10,007,017		10,007,017	153,851	10,160,868	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	280,835		280,835	0	280,835	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	302,438		302,438	0	302,438	54.00
60.00	06000 LABORATORY	319,490		319,490	0	319,490	60.00
65.00	06500 RESPIRATORY THERAPY	1,131,884	0	1,131,884	0	1,131,884	65.00
66.00	06600 PHYSICAL THERAPY	1,445,803	0	1,445,803	0	1,445,803	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	203,611		203,611	0	203,611	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,614,919		1,614,919	0	1,614,919	73.00
74.00	07400 RENAL DIALYSIS	363,530		363,530	0	363,530	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)	15,669,527	0	15,669,527	153,851	15,823,378	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	15,669,527	0	15,669,527	153,851	15,823,378	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet C
Part I
Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description		Title XIX			Hospital	Cost		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
6.00	7.00	8.00	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,816,197		26,816,197			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	291,515	0	291,515	0.963364	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,446,846	0	1,446,846	0.209033	0.000000	54.00
60.00	06000	LABORATORY	3,068,509	0	3,068,509	0.104119	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,084,795	0	8,084,795	0.140002	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,721,309	0	1,721,309	0.839944	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	628,332	0	628,332	0.324050	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,734,468	0	9,734,468	0.165897	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,005,270	0	1,005,270	0.361624	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)	52,797,241	0	52,797,241			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	52,797,241	0	52,797,241			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet C Part I Date/Time Prepared: 1/26/2018 2:25 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
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: 14-2013		Period: From 09/01/2016 To 08/31/2017		Worksheet D Part I Date/Time Prepared: 1/26/2018 2:25 pm	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,022,598	0	2,022,598	8,074	250.51	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)	2,022,598		2,022,598	8,074		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	4,952	1,240,526				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	4,952	1,240,526				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part II Date/Time Prepared: 1/26/2018 2:25 pm
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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	6,867	291,515	0.023556	263,557	6,208	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	64,547	1,446,846	0.044612	845,854	37,735	54.00
60.00	06000 LABORATORY	22,168	3,068,509	0.007224	1,931,768	13,955	60.00
65.00	06500 RESPIRATORY THERAPY	67,539	8,084,795	0.008354	4,874,371	40,720	65.00
66.00	06600 PHYSICAL THERAPY	622,700	1,721,309	0.361760	1,019,972	368,985	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	25,739	628,332	0.040964	352,872	14,455	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	84,324	9,734,468	0.008662	5,694,609	49,327	73.00
74.00	07400 RENAL DIALYSIS	6,300	1,005,270	0.006267	565,214	3,542	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	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (Lines 50-199)	900,184	25,981,044		15,548,217	534,927	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-2013		Period: From 09/01/2016 To 08/31/2017		Worksheet D Part III Date/Time Prepared: 1/26/2018 2:25 pm	
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	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	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	8,074	0.00	4,952	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)	8,074		4,952	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet D
Part IV
Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description		Title XVIII			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared: 1/26/2018 2:25 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		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	291,515	0.000000	0.000000	263,557	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,446,846	0.000000	0.000000	845,854	54.00
60.00	06000 LABORATORY	0	3,068,509	0.000000	0.000000	1,931,768	60.00
65.00	06500 RESPIRATORY THERAPY	0	8,084,795	0.000000	0.000000	4,874,371	65.00
66.00	06600 PHYSICAL THERAPY	0	1,721,309	0.000000	0.000000	1,019,972	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	628,332	0.000000	0.000000	352,872	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,734,468	0.000000	0.000000	5,694,609	73.00
74.00	07400 RENAL DIALYSIS	0	1,005,270	0.000000	0.000000	565,214	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	0	0	0.000000	0.000000	0	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	25,981,044			15,548,217	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet D Part IV Date/Time Prepared: 1/26/2018 2:25 pm
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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		
Title XVIII Hospital PPS						
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	0	0	0		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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/26/2018 2:25 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			8,074 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			8,074 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)			8,074 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)			4,952 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)			10,160,868 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)			10,160,868 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)			10,160,868 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)			1,258.47 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,231,943 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)			6,231,943 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2013		Period: From 09/01/2016 To 08/31/2017		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 1/26/2018 2:25 pm	
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)					3,434,449		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,666,392		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)					1,240,526		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					534,927		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,775,453		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,890,939		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: 14-2013		Period: From 09/01/2016 To 08/31/2017		Worksheet D-1 Date/Time Prepared: 1/26/2018 2:25 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,022,598	10,160,868	0.199058	0	0	90.00
91.00	Nursing School cost	0	10,160,868	0.000000	0	0	91.00
92.00	Allied health cost	0	10,160,868	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,160,868	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/26/2018 2:25 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			8,074 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			8,074 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)			8,074 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)			20 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)			10,007,017 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)			10,007,017 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)			10,007,017 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)			1,239.41 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			24,788 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)			24,788 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2013		Period: From 09/01/2016 To 08/31/2017		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 1/26/2018 2:25 pm	
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)					9,059	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					33,847	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: 14-2013		Period: From 09/01/2016 To 08/31/2017		Worksheet D-1 Date/Time Prepared: 1/26/2018 2:25 pm	
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	2,022,598	10,007,017	0.202118	0	0	90.00
91.00	Nursing School cost	0	10,007,017	0.000000	0	0	91.00
92.00	Allied health cost	0	10,007,017	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,007,017	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet D-2
Date/Time Prepared:
1/26/2018 2:25 pm

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																				
Hospital Inpatient Routine Services:																				
1.00 Total cost of services rendered	0.00	0				1.00														
2.00 ADULTS & PEDIATRICS	0.00	0	8,074	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														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th>Percent of Assigned Time</th> <th>Expense Allocation</th> <th>Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)</th> <th>Ratio of Cost to Charges (col. 2 ÷ col. 3)</th> <th>Titles V and XIX Outpatient and Title XVIII Part B Charges Title V</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description	Percent of Assigned Time	Expense Allocation	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	
Cost Center Description	Percent of Assigned Time	Expense Allocation	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 CLINIC	0.00	0	0	0.000000	0	22.00														
23.00 CLINIC	0.00	0	0	0.000000	0	23.00														
24.00 EMERGENCY						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														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th>Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22</th> <th>Swing bed Amount</th> <th>Net cost (column 1 plus column 2)</th> <th>Total Inpatient Days - All Patients</th> <th>Average Cost Per Day (col. 3 ÷ col. 4)</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							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	
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	8,074	0.00	29.00														
30.00 Swing Bed - SNF				0	0.00	30.00														
31.00 Swing Bed - NF				0		31.00														
32.00 INTENSIVE CARE UNIT	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	0.00	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: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet D-2

Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description	Not In Approved Teaching Program		In Approved Teaching Program	
	(from Part I:)	Amount	(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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet D-2 Date/Time Prepared: 1/26/2018 2:25 pm
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Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX				
	6.00	7.00				
PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00 Total cost of services rendered						1.00
Hospital Inpatient Routine Services:						
2.00 ADULTS & PEDIATRICS	4,952	20	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		Titles V and XIX Outpatient and Title XVIII Part B Cost		
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	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: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet D-2

Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs			
	Amount	(to Wkst. E, Part B -)	(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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet D-3 Date/Time Prepared: 1/26/2018 2:25 pm	
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		16,382,485		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.963364	263,557	253,901	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.209033	845,854	176,811	54.00
60.00	06000 LABORATORY	0.104119	1,931,768	201,134	60.00
65.00	06500 RESPIRATORY THERAPY	0.140002	4,874,371	682,422	65.00
66.00	06600 PHYSICAL THERAPY	0.839944	1,019,972	856,719	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	0.324050	352,872	114,348	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.165897	5,694,609	944,719	73.00
74.00	07400 RENAL DIALYSIS	0.361624	565,214	204,395	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)		15,548,217	3,434,449	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)		15,548,217		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet D-3 Date/Time Prepared: 1/26/2018 2:25 pm	
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		69,110	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.963364	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209033	824	54.00
60.00	06000	LABORATORY	0.104119	3,372	60.00
65.00	06500	RESPIRATORY THERAPY	0.140002	12,986	65.00
66.00	06600	PHYSICAL THERAPY	0.839944	425	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324050	933	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.165897	9,580	73.00
74.00	07400	RENAL DIALYSIS	0.361624	12,362	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		40,482	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)		40,482	202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet E-1
Part I
Date/Time Prepared:
1/26/2018 2:25 pm

		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		8,569,407		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	09/19/2017	695,264		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)		-695,264		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)		7,874,143		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		68,935		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		7,943,078		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part IV Date/Time Prepared: 1/26/2018 2:25 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		7,223,472	1.00
1.01	Full standard payment amount		5,921,523	1.01
1.02	Short stay outlier standard payment amount		964,002	1.02
1.03	Site neutral payment amount - Cost		30,535	1.03
1.04	Site neutral payment amount - IPPS comparable		307,411	1.04
2.00	Outlier Payments		1,131,578	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		8,355,050	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)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		8,355,050	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		8,355,050	9.00
10.00	Deductibles		41,720	10.00
11.00	Subtotal (line 9 minus line 10)		8,313,330	11.00
12.00	Coinsurance		297,206	12.00
13.00	Subtotal (line 11 minus line 12)		8,016,124	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		137,012	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		89,058	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		118,595	16.00
17.00	Subtotal (sum of lines 13 and 15)		8,105,182	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)		8,105,182	22.00
22.01	Sequestration adjustment (see instructions)		162,104	22.01
23.00	Interim payments		7,874,143	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)		68,935	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)		1,131,578	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: 14-2013	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 1/26/2018 2:25 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		33,847		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)		33,847	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)		33,847	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		69,110		8.00
9.00	Ancillary service charges		40,482	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)		109,592	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)		109,592	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		75,745	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)		33,847	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)		33,847	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)		33,847	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		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)		33,847	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)		33,847	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)		33,847	0	40.00
41.00	Interim payments		11,657		41.00
42.00	Balance due provider/program (line 40 minus line 41)		22,190		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: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet G

Date/Time Prepared:
1/26/2018 2:25 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	765,157	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	2,504,348	0	0	0	4.00
5.00	Other receivable	5,563	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-612,895	0	0	0	6.00
7.00	Inventory	204,782	0	0	0	7.00
8.00	Prepaid expenses	165,736	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)	3,032,691	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	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	197,980	0	0	0	17.00
18.00	Accumulated depreciation	-158,993	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	910,188	0	0	0	23.00
24.00	Accumulated depreciation	-582,073	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)	367,102	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	17,105	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,105	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	3,416,898	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	352,077	0	0	0	37.00
38.00	Salaries, wages, and fees payable	362,348	0	0	0	38.00
39.00	Payroll taxes payable	14,547	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	535,577	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,264,549	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	3,913,011	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,913,011	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,177,560	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-1,760,662	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,760,662	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	3,416,898	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet G-1

Date/Time Prepared:
1/26/2018 2:25 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-215,323			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,545,338				2.00
3.00	Total (sum of line 1 and line 2)		-1,760,661			0	3.00
4.00	Additions (credit adjustments)	0		0		0	4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		-1,760,661			0	11.00
12.00	Deductions (debit adjustments)	0		0		0	12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	1		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)		1			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,760,662			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: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/26/2018 2:25 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	26,816,197		26,816,197	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)	26,816,197		26,816,197	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)	26,816,197		26,816,197	17.00
18.00	Ancillary services	25,981,044	0	25,981,044	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)	52,797,241	0	52,797,241	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,188,667		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)		15,188,667		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-2013

Period:
From 09/01/2016
To 08/31/2017

Worksheet G-3

Date/Time Prepared:
1/26/2018 2:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	52,797,241	1.00
2.00	Less contractual allowances and discounts on patients' accounts	39,562,342	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,234,899	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,188,667	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,953,768	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,020	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	1,690	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	19,657	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	836	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	385,227	24.00
25.00	Total other income (sum of lines 6-24)	408,430	25.00
26.00	Total (line 5 plus line 25)	-1,545,338	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)	-1,545,338	29.00