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: 14-0040	Period: From 05/01/2017 To 04/30/2018	Worksheet S Parts I-III Date/Time Prepared: 9/25/2018 5:32 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/25/2018 Time: 5:32 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL 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 GALESBURG COTTAGE HOSPITAL (14-0040) for the cost reporting period beginning 05/01/2017 and ending 04/30/2018 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.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-171,156	15,331	0	0	1.00
2.00	Subprovider - IPF	0	28,577	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	5,001	0		0	7.00
200.00	Total	0	-137,578	15,331	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2018 5:30 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 695 NORTH KELLOGG STREET	PO Box:			1.00
2.00	City: GALESBURG	State: IL	Zip Code: 61401	County: KNOX	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GALESBURG COTTAGE HOSPITAL	140040	99914	1	07/06/1966	N	P	P	3.00
4.00	Subprovider - IPF	GALEBSURG COTTAGE PSYCH	14S040	99914	4	05/01/2006	N	P	N	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	GALESBURG COTTAGE SKILLED UNIT	145690	99914		01/11/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2017	04/30/2018	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.	Y	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)	Y	Y	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.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	591	403	0	0	1,085	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2018 5:30 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		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.	05/01/2017	04/30/2018	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)(i) or (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)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) 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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (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)						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)						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)						61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2018 5:30 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						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)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						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. Enter in column 4, the 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. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2018 5:30 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is 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)	N	N	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 is 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2018 5:30 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2018 5:30 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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:	50,976	12,335	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
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	449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2018 5:30 pm

	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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BOULEVARD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	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)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04/01/2017	06/29/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 9/25/2018 5:30 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	08/30/2018	Y	08/30/2018	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: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 9/25/2018 5:30 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.	BRENT		WILSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615 221-3647		BRENT_WILSON@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0040	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part II Date/Time Prepared: 9/25/2018 5:30 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.	SENIOR DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 9/25/2018 5:30 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	111	40,515	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)		111	40,515	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	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	43.00				0	13.00
14.00	Total (see instructions)		123	44,895	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	16	5,840		0	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)		139				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
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 9/25/2018 5:30 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,917	271	6,004			1.00
2.00	HMO and other (see instructions)	1,947	1,488				2.00
3.00	HMO IPF Subprovider	80	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,917	271	6,004			7.00
8.00	INTENSIVE CARE UNIT	727	70	1,377			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		250	758			13.00
14.00	Total (see instructions)	3,644	591	8,139	0.00	249.58	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	3,292	74	4,236	0.00	22.44	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	272.02	27.00
28.00	Observation Bed Days		0	828			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	16			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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 9/25/2018 5:30 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	867	497	2,125	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	867	497	2,125	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	173	3	248	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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 9/25/2018 5:30 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. 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	16,133,057	0	16,133,057	565,799.00	28.51	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,332,634	17,304	1,349,938	50,488.00	26.74	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		782,597	0	782,597	9,658.00	81.03	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		512,685	0	512,685	6,997.00	73.27	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,382,968	0	4,382,968			17.00
18.00	Wage-related costs (other) (see instructions)		93,662	0	93,662			18.00
19.00	Excluded areas		428,509	0	428,509			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	169,801	0	169,801	5,069.00	33.50	26.00
27.00	Administrative & General	5.00	2,064,674	-154,718	1,909,956	74,947.00	25.48	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 9/25/2018 5:30 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. 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.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	472,811	0	472,811	18,937.00	24.97	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	479,321	0	479,321	33,176.00	14.45	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,159,844	66,384	1,226,228	33,967.00	36.10	38.00
39.00	Central Services and Supply	14.00	91,848	0	91,848	6,327.00	14.52	39.00
40.00	Pharmacy	15.00	544,115	0	544,115	13,595.00	40.02	40.00
41.00	Medical Records & Medical Records Library	16.00	324,790	0	324,790	16,878.00	19.24	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 9/25/2018 5:30 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		16,133,057	0	16,133,057	565,799.00	28.51	1.00
2.00	Excluded area salaries (see instructions)		1,332,634	17,304	1,349,938	50,488.00	26.74	2.00
3.00	Subtotal salaries (line 1 minus line 2)		14,800,423	-17,304	14,783,119	515,311.00	28.69	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,295,282	0	1,295,282	16,655.00	77.77	4.00
5.00	Subtotal wage-related costs (see inst.)		4,476,630	0	4,476,630	0.00	30.28	5.00
6.00	Total (sum of lines 3 thru 5)		20,572,335	-17,304	20,555,031	531,966.00	38.64	6.00
7.00	Total overhead cost (see instructions)		5,307,204	-88,334	5,218,870	202,896.00	25.72	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 9/25/2018 5:30 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	272,381	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)	0	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)	2,547,315	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	15,421	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	13,879	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-369	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	10,794	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	298,027	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	927,979	17.00
18.00	Medicare Taxes - Employers Portion Only	217,027	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	99,713	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,402,167	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER BENEFITS	93,662	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 9/25/2018 5:30 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	782,597	4,717,816	1.00
2.00	Hospital	782,597	4,717,816	2.00
3.00	Subprovider - IPF	0	0	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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-7 | Date/Time Prepared: 9/25/2018 5:30 pm

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

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-7 | Date/Time Prepared: 9/25/2018 5:30 pm

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

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

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-10 | Date/Time Prepared: 9/25/2018 5:30 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.114736	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,469,184	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	11,384,093	5.00
6.00	Medicaid charges	79,866,072	6.00
7.00	Medicaid cost (line 1 times line 6)	9,163,514	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,641,553	21,928	2,663,481	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	303,081	21,928	325,009	21.00
22.00	Payments received from patients for amounts previously written off as charity care	11,733	0	11,733	22.00
23.00	Cost of charity care (line 21 minus line 22)	291,348	21,928	313,276	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,376,391	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	314,657	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	484,086	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,892,305	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	386,545	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	699,821	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	699,821	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A | Date/Time Prepared: 9/25/2018 5:30 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,366,602	1,366,602	-273,771	1,092,831	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,943,486	1,943,486	717,215	2,660,701	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	169,801	170,341	340,142	3,179,563	3,519,705	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,064,674	14,450,283	16,514,957	-3,358,033	13,156,924	5.00
7.00	00700	OPERATION OF PLANT	472,811	1,505,327	1,978,138	0	1,978,138	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	148,725	148,725	0	148,725	8.00
9.00	00900	HOUSEKEEPING	479,321	207,716	687,037	0	687,037	9.00
10.00	01000	DIETARY	0	934,499	934,499	-675,096	259,403	10.00
11.00	01100	CAFETERIA	0	0	0	675,096	675,096	11.00
13.00	01300	NURSING ADMINISTRATION	1,159,844	152,554	1,312,398	87,607	1,400,005	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	91,848	2,795,432	2,887,280	-2,688,864	198,416	14.00
15.00	01500	PHARMACY	544,115	1,414,329	1,958,444	-1,222,928	735,516	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	324,790	286,016	610,806	0	610,806	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,986,323	1,363,490	3,349,813	1,180,073	4,529,886	30.00
31.00	03100	INTENSIVE CARE UNIT	1,124,972	302,859	1,427,831	-1,440	1,426,391	31.00
40.00	04000	SUBPROVIDER - IPF	1,232,901	587,001	1,819,902	-1,550	1,818,352	40.00
43.00	04300	NURSERY	20	767	787	570,999	571,786	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,173,743	824,920	1,998,663	225,850	2,224,513	50.00
51.00	05100	RECOVERY ROOM	267,651	28,421	296,072	-296,072	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,128,639	1,209,692	2,338,331	-1,756,394	581,937	52.00
53.00	05300	ANESTHESIOLOGY	12,056	1,700,042	1,712,098	0	1,712,098	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	599,161	588,413	1,187,574	827,688	2,015,262	54.00
54.01	05401	ULTRASOUND	91,470	39,612	131,082	-131,082	0	54.01
56.00	05600	RADIOISOTOPE	55,514	324,929	380,443	-380,443	0	56.00
57.00	05700	CT SCAN	138,813	275,959	414,772	-414,772	0	57.00
58.00	05800	MRI	93,586	216,365	309,951	-309,951	0	58.00
60.00	06000	LABORATORY	956,491	1,175,645	2,132,136	-76,076	2,056,060	60.00
65.00	06500	RESPIRATORY THERAPY	289,086	141,417	430,503	50,923	481,426	65.00
66.00	06600	PHYSICAL THERAPY	0	376,148	376,148	214,696	590,844	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	114,448	114,448	-114,448	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	100,248	100,248	-100,248	0	68.00
69.00	06900	ELECTROCARDIOLOGY	368,915	300,970	669,885	-20,750	649,135	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	935,325	935,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,738,747	1,738,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,132,548	1,132,548	73.00
74.00	07400	RENAL DIALYSIS	0	172,500	172,500	0	172,500	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	54,254	8,376	62,630	-62,630	0	76.01
76.03	03950	WOUND CARE	149,142	591,845	740,987	-971	740,016	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,003,383	1,367,994	2,371,377	1,882,336	4,253,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	71,030	1,814,086	1,885,116	-1,885,116	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,104,354	39,001,457	55,105,811	-351,969	54,753,842	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,703	26,419	55,122	0	55,122	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-9,364	-9,364	0	-9,364	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	351,969	351,969	194.01
194.02	07952	SENIOR CIRCLE	0	13,285	13,285	0	13,285	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	16,133,057	39,031,797	55,164,854	0	55,164,854	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A | Date/Time Prepared: 9/25/2018 5:30 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	-201,081	891,750		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-6,125	2,654,576		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,519,705		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,680,447	10,476,477		5.00
7.00	00700	OPERATION OF PLANT	0	1,978,138		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	148,725		8.00
9.00	00900	HOUSEKEEPING	0	687,037		9.00
10.00	01000	DIETARY	0	259,403		10.00
11.00	01100	CAFETERIA	0	675,096		11.00
13.00	01300	NURSING ADMINISTRATION	-3,157	1,396,848		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	198,416		14.00
15.00	01500	PHARMACY	0	735,516		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	610,806		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,488,345	3,041,541		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,426,391		31.00
40.00	04000	SUBPROVIDER - IPF	-373,125	1,445,227		40.00
43.00	04300	NURSERY	-276,913	294,873		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,224,513		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	581,937		52.00
53.00	05300	ANESTHESIOLOGY	-1,628,683	83,415		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,015,262		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	-90,000	1,966,060		60.00
65.00	06500	RESPIRATORY THERAPY	0	481,426		65.00
66.00	06600	PHYSICAL THERAPY	0	590,844		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	-2,500	646,635		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	935,325		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,738,747		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,132,548		73.00
74.00	07400	RENAL DIALYSIS	0	172,500		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03950	WOUND CARE	-450	739,566		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-2,647,533	1,606,180		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,398,359	45,355,483		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	55,122		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-9,364		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	351,969		194.01
194.02	07952	SENIOR CIRCLE	0	13,285		194.02
194.03	07953	UNUSED SPACE	0	0		194.03
194.04	07954	GUEST MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,398,359	45,766,495		200.00

RECLASSIFICATIONS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-6 | Date/Time Prepared: 9/25/2018 5:30 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,179,563	1.00
	0		0	3,179,563	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	105,662	1.00
	0		0	105,662	
	C - RENTAL AND LEASE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	713,000	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	0		0	713,000	
	D - OTHER CAP COSTS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,215	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	269,556	2.00
	0		0	273,771	
	E - MARKETING DEPT				
1.00	MARKETING	194.01	88,334	263,635	1.00
	0		88,334	263,635	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	829,663	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,738,747	2.00
	0		0	2,568,410	
	G - COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,132,548	1.00
	0		0	1,132,548	
	H - LABOR AND DELIV				
1.00	ADULTS & PEDIATRICS	30.00	571,527	613,170	1.00
2.00	NURSERY	43.00	275,741	295,258	2.00
	0		847,268	908,428	
	I - THERAPY COSTS				
1.00	PHYSICAL THERAPY	66.00	0	214,696	1.00
2.00		0.00	0	0	2.00
	0		0	214,696	
	J - MISCELLANEOUS DEPTS				
1.00	NURSING ADMINISTRATION	13.00	66,384	21,970	1.00
2.00	OPERATING ROOM	50.00	267,651	28,421	2.00
3.00	RESPIRATORY THERAPY	65.00	54,254	8,376	3.00
4.00	EMERGENCY	91.00	71,030	1,814,086	4.00
	0		459,319	1,872,853	
	K - OTHER RADIOLOGY COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	379,383	856,865	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		379,383	856,865	
	L - DIETARY TO CAFETERIA				
1.00	CAFETERIA	11.00	0	675,096	1.00
	0		0	675,096	
500.00	Grand Total: Increases		1,774,304	12,764,527	500.00

RECLASSIFICATIONS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-6 | Date/Time Prepared: 9/25/2018 5:30 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,179,563	0		1.00
	0		0	3,179,563			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	105,662	0		1.00
	0		0	105,662			
	C - RENTAL AND LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,703	10		1.00
2.00	NURSING ADMINISTRATION	13.00	0	747	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,792	0		3.00
4.00	PHARMACY	15.00	0	90,380	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	4,624	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	1,440	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	1,550	0		7.00
8.00	OPERATING ROOM	50.00	0	68,935	0		8.00
9.00	OPERATING ROOM	50.00	0	1,287	0		9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	698	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	222,061	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	27,965	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	157,833	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	701	0		14.00
15.00	LABORATORY	60.00	0	76,076	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	11,707	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	20,750	0		17.00
18.00	WOUND CARE	76.03	0	971	0		18.00
19.00	EMERGENCY	91.00	0	2,780	0		19.00
	0		0	713,000			
	D - OTHER CAP COSTS						
1.00		0.00	0	0	12		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	273,771	13		2.00
	0		0	273,771			
	E - MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	88,334	263,635	0		1.00
	0		88,334	263,635			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,568,410	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	2,568,410			
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	1,132,548	0		1.00
	0		0	1,132,548			
	H - LABOR AND DELIV						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	847,268	908,428	0		1.00
2.00		0.00	0	0	0		2.00
	0		847,268	908,428			
	I - THERAPY COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	0	114,448	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	100,248	0		2.00
	0		0	214,696			
	J - MISCELLANEOUS DEPTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	66,384	21,970	0		1.00
2.00	RECOVERY ROOM	51.00	267,651	28,421	0		2.00
3.00	SLEEP LAB	76.01	54,254	8,376	0		3.00
4.00	AMBULANCE SERVICES	95.00	71,030	1,814,086	0		4.00
	0		459,319	1,872,853			
	K - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	91,470	39,612	0		1.00
2.00	RADIOISOTOPE	56.00	55,514	324,929	0		2.00
3.00	CT SCAN	57.00	138,813	275,959	0		3.00
4.00	MRI	58.00	93,586	216,365	0		4.00
	0		379,383	856,865			
	L - DIETARY TO CAFETERIA						
1.00	DIETARY	10.00	0	675,096	0		1.00
	0		0	675,096			
500.00	Grand Total: Decreases		1,774,304	12,764,527			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 9/25/2018 5:30 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	448,254	0	0	0	188,986	1.00
2.00	Land Improvements	621,460	0	0	0	67,080	2.00
3.00	Buildings and Fixtures	15,710,178	16,193	0	16,193	0	3.00
4.00	Building Improvements	15,010,440	224,937	0	224,937	115,684	4.00
5.00	Fixed Equipment	4,504,035	78,159	0	78,159	437,811	5.00
6.00	Movable Equipment	18,728,321	633,907	0	633,907	2,085,078	6.00
7.00	HIT designated Assets	4,749,945	0	0	0	3,316	7.00
8.00	Subtotal (sum of lines 1-7)	59,772,633	953,196	0	953,196	2,897,955	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	59,772,633	953,196	0	953,196	2,897,955	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	259,268	0	1.00
2.00	Land Improvements	554,380	0	2.00
3.00	Buildings and Fixtures	15,726,371	0	3.00
4.00	Building Improvements	15,119,693	0	4.00
5.00	Fixed Equipment	4,144,383	0	5.00
6.00	Movable Equipment	17,277,150	0	6.00
7.00	HIT designated Assets	4,746,629	0	7.00
8.00	Subtotal (sum of lines 1-7)	57,827,874	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	57,827,874	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 9/25/2018 5:30 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	1,366,602	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,943,486	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,310,088	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,366,602	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,943,486	2.00
3.00	Total (sum of lines 1-2)	0	3,310,088	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 9/25/2018 5:30 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	31,659,713	0	31,659,713	0.547482	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,168,163	0	26,168,163	0.452518	0	2.00
3.00	Total (sum of lines 1-2)	57,827,876	0	57,827,876	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,165,521	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,937,361	713,000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,102,882	713,000	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	-273,771	0	891,750	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,215	0	0	2,654,576	2.00
3.00	Total (sum of lines 1-2)	0	4,215	-273,771	0	3,546,326	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8 | Date/Time Prepared: 9/25/2018 5:30 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-19,889	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,197	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,510,706			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,499,499			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	0	CAP REL COSTS-BLDG & FIXT	1.00	14	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	B	0	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	0	ADMINISTRATIVE & GENERAL	5.00	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	A	-341,654	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-17,414	CAP REL COSTS-MVBLE EQUIP	2.00	9	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	LOBBYING EXPENSES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8 | Date/Time Prepared: 9/25/2018 5:30 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	
36.00	OTHER MISCELLANEOUS REVENUE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	DEPRECIATION - ADMIN AND GENERAL	A	0	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PATIENT PHONE WAGE COST	A	0	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	PATIENT PHONES BENEFITS COST	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	PATIENT PHONES DEPRECIATION COST	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00	PATIENT TV CABLE EXPENSE	A	0	OPERATION OF PLANT	7.00	0	42.00
43.00	MARKETING EXP - EXCL MARKETING DEPT	A	0	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	ILLINOIS PROVIDER TAX	A	0	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	PHYSICIAN RECRUITING	A	0	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	CHARITABLE CONTRIBUTIONS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00	PENALTIES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00	CLUB DUES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	49.00
49.01	MINORITY INTEREST	A	0	CAP REL COSTS-BLDG & FIXT	1.00	14	49.01
49.02	NONALLOWABLE LEGAL FEES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	49.02
49.06	SPECIAL EVENTS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	49.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,398,359				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: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 9/25/2018 5:30 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	DIRECT ALLOCATION - QHR COST	15,870	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	366,198	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	140,573	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	20,486	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	600,140	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	3,027,513	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	63,311	678,564	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.17	0.00			0	0	4.17
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,206,578	3,706,077	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B	QUORUM HEALTH C	100.00	QHC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 14-0040	Period: From 05/01/2017 To 04/30/2018	Worksheet A-8-1 Date/Time Prepared: 9/25/2018 5:30 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	15,870	0		1.00
2.00	366,198	0		2.00
3.00	140,573	9		3.00
4.00	20,486	9		4.00
4.01	600,140	0		4.01
4.02	-3,027,513	0		4.02
4.03	-615,253	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.17	0	0		4.17
4.20	0	0		4.20
4.21	0	0		4.21
5.00	-2,499,499			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	HOSPITAL CORP		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 9/25/2018 5:30 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	13.00	NURSING ADMINISTRATION	15,600	500	15,100	171,400	151	1.00
2.00	30.00	ADULTS & PEDIATRICS	914,390	914,390	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	373,125	373,125	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,628,683	1,628,683	0	0	0	5.00
6.00	60.00	LABORATORY	90,000	90,000	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	2,500	2,500	0	0	0	7.00
8.00	76.03	WOUND CARE	450	450	0	0	0	8.00
9.00	91.00	EMERGENCY	2,647,533	2,647,533	0	0	0	9.00
10.00	43.00	NURSERY	276,913	276,913	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	573,955	573,955	0	0	0	11.00
200.00			6,523,149	6,508,049	15,100		151	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	13.00	NURSING ADMINISTRATION	12,443	622	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.03	WOUND CARE	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	43.00	NURSERY	0	0	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	11.00
200.00			12,443	622	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	13.00	NURSING ADMINISTRATION	0	12,443	2,657	3,157		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	914,390		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	373,125		3.00
4.00	0.00		0	0	0	0		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,628,683		5.00
6.00	60.00	LABORATORY	0	0	0	90,000		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,500		7.00
8.00	76.03	WOUND CARE	0	0	0	450		8.00
9.00	91.00	EMERGENCY	0	0	0	2,647,533		9.00
10.00	43.00	NURSERY	0	0	0	276,913		10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	573,955		11.00
200.00			0	12,443	2,657	6,510,706		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I Date/Time Prepared: 9/25/2018 5:30 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	891,750	891,750				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,654,576		2,654,576			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,519,705	3,119	9,284	3,532,108		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,476,477	116,495	346,784	422,606	11,362,362	5.00
7.00	00700	OPERATION OF PLANT	1,978,138	264,788	788,232	104,617	3,135,775	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	148,725	6,602	19,653	0	174,980	8.00
9.00	00900	HOUSEKEEPING	687,037	9,485	28,235	106,057	830,814	9.00
10.00	01000	DIETARY	259,403	24,125	71,815	0	355,343	10.00
11.00	01100	CAFETERIA	675,096	11,754	34,989	0	721,839	11.00
13.00	01300	NURSING ADMINISTRATION	1,396,848	13,106	39,013	271,321	1,720,288	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	198,416	25,819	76,857	20,323	321,415	14.00
15.00	01500	PHARMACY	735,516	9,516	28,327	120,394	893,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	610,806	26,424	78,660	71,865	787,755	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,041,541	92,079	274,101	565,959	3,973,680	30.00
31.00	03100	INTENSIVE CARE UNIT	1,426,391	15,041	44,773	248,917	1,735,122	31.00
40.00	04000	SUBPROVIDER - IPF	1,445,227	27,518	81,916	272,798	1,827,459	40.00
43.00	04300	NURSERY	294,873	3,921	11,671	61,016	371,481	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,224,513	53,468	159,166	318,930	2,756,077	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	581,937	0	0	62,258	644,195	52.00
53.00	05300	ANESTHESIOLOGY	83,415	1,200	3,573	2,668	90,856	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,015,262	36,030	107,254	216,518	2,375,064	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,966,060	23,407	69,677	211,638	2,270,782	60.00
65.00	06500	RESPIRATORY THERAPY	481,426	9,233	27,484	75,969	594,112	65.00
66.00	06600	PHYSICAL THERAPY	590,844	11,072	32,960	0	634,876	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
69.00	06900	ELECTROCARDIOLOGY	646,635	23,076	68,692	81,628	820,031	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	935,325	0	0	0	935,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,738,747	0	0	0	1,738,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,132,548	0	0	0	1,132,548	73.00
74.00	07400	RENAL DIALYSIS	172,500	0	0	0	172,500	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	739,566	14,530	43,254	33,000	830,350	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,606,180	17,453	51,953	237,730	1,913,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,355,483	839,261	2,498,323	3,506,212	45,120,845	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	55,122	8,203	24,420	6,351	94,096	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-9,364	2,605	7,756	0	997	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	351,969	0	0	19,545	371,514	194.01
194.02	07952	SENIOR CIRCLE	13,285	0	0	0	13,285	194.02
194.03	07953	UNUSED SPACE	0	41,681	124,077	0	165,758	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,766,495	891,750	2,654,576	3,532,108	45,766,495	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/25/2018 5:30 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	11,362,362					5.00
7.00	00700	OPERATION OF PLANT	1,035,627	4,171,402				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	57,789	54,281	287,050			8.00
9.00	00900	HOUSEKEEPING	274,386	77,985	0	1,183,185		9.00
10.00	01000	DIETARY	117,356	198,353	0	58,103	729,155	10.00
11.00	01100	CAFETERIA	238,396	96,640	0	28,309	0	11.00
13.00	01300	NURSING ADMINISTRATION	568,146	107,754	0	31,564	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106,151	212,280	4,344	62,183	0	14.00
15.00	01500	PHARMACY	295,173	78,239	0	22,919	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	260,166	217,261	0	63,642	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,312,340	757,069	89,671	221,771	312,530	30.00
31.00	03100	INTENSIVE CARE UNIT	573,045	123,665	32,058	36,225	62,416	31.00
40.00	04000	SUBPROVIDER - IPF	603,540	226,254	27,119	66,277	259,929	40.00
43.00	04300	NURSERY	122,686	32,236	0	9,443	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	910,228	439,618	28,605	128,777	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	212,753	0	0	0	48,721	52.00
53.00	05300	ANESTHESIOLOGY	30,006	9,869	0	2,891	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	784,393	296,238	25,144	86,777	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	749,953	192,450	1,537	56,374	0	60.00
65.00	06500	RESPIRATORY THERAPY	196,213	75,910	0	22,236	0	65.00
66.00	06600	PHYSICAL THERAPY	209,675	91,037	0	26,667	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
69.00	06900	ELECTROCARDIOLOGY	270,825	189,729	3,808	55,577	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	308,902	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	574,242	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	374,038	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	56,970	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	274,233	119,468	9,009	34,996	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	631,896	143,496	48,863	42,034	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,149,128	3,739,832	270,158	1,056,765	683,596	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,076	67,447	0	19,757	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	329	21,422	16,892	6,275	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	122,697	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	4,388	0	0	0	31,721	194.02
194.03	07953	UNUSED SPACE	54,744	342,701	0	100,388	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	13,838	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,362,362	4,171,402	287,050	1,183,185	729,155	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/25/2018 5:30 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	1,085,184					11.00
13.00	01300	NURSING ADMINISTRATION	85,018	2,512,770				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,827	0	722,200			14.00
15.00	01500	PHARMACY	34,049	0	2,073	1,326,206		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,222	0	1,548	0	1,372,594	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	208,350	803,338	25,409	0	87,207	30.00
31.00	03100	INTENSIVE CARE UNIT	90,380	353,318	16,558	0	34,297	31.00
40.00	04000	SUBPROVIDER - IPF	116,828	387,215	5,158	0	56,102	40.00
43.00	04300	NURSERY	18,899	86,608	140	0	6,730	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	105,947	452,696	120,800	0	281,828	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,263	88,370	19,691	0	6,848	52.00
53.00	05300	ANESTHESIOLOGY	885	3,786	7,566	0	87,609	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,792	0	17,226	0	204,221	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	111,830	0	84,802	0	247,975	60.00
65.00	06500	RESPIRATORY THERAPY	32,383	0	6,772	0	25,318	65.00
66.00	06600	PHYSICAL THERAPY	0	0	94	0	11,814	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
69.00	06900	ELECTROCARDIOLOGY	30,404	0	798	0	53,150	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	82,972	0	21,256	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	295,382	0	62,156	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,326,206	31,143	73.00
74.00	07400	RENAL DIALYSIS	0	0	78	0	2,819	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	11,558	0	9,987	0	23,712	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	75,022	337,439	25,013	0	128,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,075,657	2,512,770	722,067	1,326,206	1,372,594	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,321	0	18	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	5,206	0	115	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,085,184	2,512,770	722,200	1,326,206	1,372,594	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/25/2018 5:30 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	7,791,365	0	7,791,365		30.00
31.00	03100	INTENSIVE CARE UNIT	3,057,084	0	3,057,084		31.00
40.00	04000	SUBPROVIDER - IPF	3,575,881	0	3,575,881		40.00
43.00	04300	NURSERY	648,223	0	648,223		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,224,576	0	5,224,576		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,039,841	0	1,039,841		52.00
53.00	05300	ANESTHESIOLOGY	233,468	0	233,468		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,865,855	0	3,865,855		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	3,715,703	0	3,715,703		60.00
65.00	06500	RESPIRATORY THERAPY	952,944	0	952,944		65.00
66.00	06600	PHYSICAL THERAPY	974,163	0	974,163		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,424,322	0	1,424,322		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,348,455	0	1,348,455		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,670,527	0	2,670,527		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,863,935	0	2,863,935		73.00
74.00	07400	RENAL DIALYSIS	232,367	0	232,367		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03950	WOUND CARE	1,313,313	0	1,313,313		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,345,488	0	3,345,488		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,277,510	0	44,277,510		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	216,715	0	216,715		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,915	0	45,915		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	499,532	0	499,532		194.01
194.02	07952	SENIOR CIRCLE	49,394	0	49,394		194.02
194.03	07953	UNUSED SPACE	663,591	0	663,591		194.03
194.04	07954	GUEST MEALS	13,838	0	13,838		194.04
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 through 201)	45,766,495	0	45,766,495		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II Date/Time Prepared: 9/25/2018 5:30 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,119	9,284	12,403	12,403	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	116,495	346,784	463,279	1,484	5.00
7.00	00700	OPERATION OF PLANT	0	264,788	788,232	1,053,020	367	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,602	19,653	26,255	0	8.00
9.00	00900	HOUSEKEEPING	0	9,485	28,235	37,720	372	9.00
10.00	01000	DIETARY	0	24,125	71,815	95,940	0	10.00
11.00	01100	CAFETERIA	0	11,754	34,989	46,743	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,106	39,013	52,119	953	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,819	76,857	102,676	71	14.00
15.00	01500	PHARMACY	0	9,516	28,327	37,843	423	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,424	78,660	105,084	252	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	92,079	274,101	366,180	1,988	30.00
31.00	03100	INTENSIVE CARE UNIT	0	15,041	44,773	59,814	874	31.00
40.00	04000	SUBPROVIDER - IPF	0	27,518	81,916	109,434	958	40.00
43.00	04300	NURSERY	0	3,921	11,671	15,592	214	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	53,468	159,166	212,634	1,120	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	219	52.00
53.00	05300	ANESTHESIOLOGY	0	1,200	3,573	4,773	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,030	107,254	143,284	760	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	23,407	69,677	93,084	743	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,233	27,484	36,717	267	65.00
66.00	06600	PHYSICAL THERAPY	0	11,072	32,960	44,032	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
69.00	06900	ELECTROCARDIOLOGY	0	23,076	68,692	91,768	287	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	14,530	43,254	57,784	116	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	17,453	51,953	69,406	835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	839,261	2,498,323	3,337,584	12,312	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,203	24,420	32,623	22	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,605	7,756	10,361	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	69	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	41,681	124,077	165,758	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	891,750	2,654,576	3,546,326	12,403	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II | Date/Time Prepared: 9/25/2018 5:30 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	464,763					5.00
7.00	00700	OPERATION OF PLANT	42,361	1,095,748				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,364	14,258	42,877			8.00
9.00	00900	HOUSEKEEPING	11,223	20,485	0	69,800		9.00
10.00	01000	DIETARY	4,800	52,103	0	3,428	156,271	10.00
11.00	01100	CAFETERIA	9,751	25,385	0	1,670	0	11.00
13.00	01300	NURSING ADMINISTRATION	23,239	28,305	0	1,862	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,342	55,762	649	3,668	0	14.00
15.00	01500	PHARMACY	12,074	20,552	0	1,352	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,642	57,070	0	3,754	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,680	198,870	13,392	13,082	66,981	30.00
31.00	03100	INTENSIVE CARE UNIT	23,440	32,484	4,789	2,137	13,377	31.00
40.00	04000	SUBPROVIDER - IPF	24,687	59,433	4,051	3,910	55,707	40.00
43.00	04300	NURSERY	5,018	8,468	0	557	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,232	115,479	4,273	7,597	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,702	0	0	0	10,442	52.00
53.00	05300	ANESTHESIOLOGY	1,227	2,592	0	171	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,085	77,816	3,756	5,119	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	30,676	50,553	230	3,326	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,026	19,940	0	1,312	0	65.00
66.00	06600	PHYSICAL THERAPY	8,577	23,914	0	1,573	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
69.00	06900	ELECTROCARDIOLOGY	11,078	49,838	569	3,279	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,635	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,489	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,300	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,330	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	11,217	31,382	1,346	2,065	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	25,847	37,694	7,299	2,480	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	456,042	982,383	40,354	62,342	146,507	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,271	17,717	0	1,166	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13	5,627	2,523	370	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	5,019	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	179	0	0	0	6,798	194.02
194.03	07953	UNUSED SPACE	2,239	90,021	0	5,922	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	2,966	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	464,763	1,095,748	42,877	69,800	156,271	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II | Date/Time Prepared: 9/25/2018 5:30 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	83,549					11.00
13.00	01300	NURSING ADMINISTRATION	6,546	113,024				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,219	0	168,387			14.00
15.00	01500	PHARMACY	2,621	0	483	75,348		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,251	0	361	0	180,414	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,040	36,133	5,924	0	11,474	30.00
31.00	03100	INTENSIVE CARE UNIT	6,958	15,892	3,861	0	4,513	31.00
40.00	04000	SUBPROVIDER - IPF	8,995	17,417	1,203	0	7,381	40.00
43.00	04300	NURSERY	1,455	3,896	33	0	886	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,157	20,363	28,166	0	36,899	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,483	3,975	4,591	0	901	52.00
53.00	05300	ANESTHESIOLOGY	68	170	1,764	0	11,527	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,912	0	4,016	0	26,870	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	8,610	0	19,772	0	32,627	60.00
65.00	06500	RESPIRATORY THERAPY	2,493	0	1,579	0	3,331	65.00
66.00	06600	PHYSICAL THERAPY	0	0	22	0	1,554	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
69.00	06900	ELECTROCARDIOLOGY	2,341	0	186	0	6,993	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	19,346	0	2,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	68,871	0	8,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	75,348	4,097	73.00
74.00	07400	RENAL DIALYSIS	0	0	18	0	371	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	890	0	2,328	0	3,120	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,776	15,178	5,832	0	16,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,815	113,024	168,356	75,348	180,414	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	333	0	4	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	401	0	27	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	83,549	113,024	168,387	75,348	180,414	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II | Date/Time Prepared: 9/25/2018 5:30 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	783,744	0	783,744		30.00
31.00	03100	INTENSIVE CARE UNIT	168,139	0	168,139		31.00
40.00	04000	SUBPROVIDER - IPF	293,176	0	293,176		40.00
43.00	04300	NURSERY	36,119	0	36,119		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	471,920	0	471,920		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,313	0	30,313		52.00
53.00	05300	ANESTHESIOLOGY	22,301	0	22,301		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	299,618	0	299,618		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	239,621	0	239,621		60.00
65.00	06500	RESPIRATORY THERAPY	73,665	0	73,665		65.00
66.00	06600	PHYSICAL THERAPY	79,672	0	79,672		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	166,339	0	166,339		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,778	0	34,778		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,538	0	100,538		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,745	0	94,745		73.00
74.00	07400	RENAL DIALYSIS	2,719	0	2,719		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03950	WOUND CARE	110,248	0	110,248		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	187,242	0	187,242		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,194,897	0	3,194,897		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	53,136	0	53,136		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,894	0	18,894		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	5,516	0	5,516		194.01
194.02	07952	SENIOR CIRCLE	6,977	0	6,977		194.02
194.03	07953	UNUSED SPACE	263,940	0	263,940		194.03
194.04	07954	GUEST MEALS	2,966	0	2,966		194.04
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 through 201)	3,546,326	0	3,546,326		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/25/2018 5:30 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	317,967					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		317,967				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,112	1,112	15,963,256			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	41,538	41,538	1,909,956	-11,362,362	34,404,133	5.00
7.00	00700	OPERATION OF PLANT	94,415	94,415	472,811	0	3,135,775	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	2,354	0	0	174,980	8.00
9.00	00900	HOUSEKEEPING	3,382	3,382	479,321	0	830,814	9.00
10.00	01000	DIETARY	8,602	8,602	0	0	355,343	10.00
11.00	01100	CAFETERIA	4,191	4,191	0	0	721,839	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	4,673	1,226,228	0	1,720,288	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,206	9,206	91,848	0	321,415	14.00
15.00	01500	PHARMACY	3,393	3,393	544,115	0	893,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	9,422	324,790	0	787,755	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,832	32,832	2,557,850	0	3,973,680	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	5,363	1,124,972	0	1,735,122	31.00
40.00	04000	SUBPROVIDER - IPF	9,812	9,812	1,232,901	0	1,827,459	40.00
43.00	04300	NURSERY	1,398	1,398	275,761	0	371,481	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,065	19,065	1,441,394	0	2,756,077	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	281,371	0	644,195	52.00
53.00	05300	ANESTHESIOLOGY	428	428	12,056	0	90,856	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,847	12,847	978,544	0	2,375,064	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	8,346	8,346	956,491	0	2,270,782	60.00
65.00	06500	RESPIRATORY THERAPY	3,292	3,292	343,340	0	594,112	65.00
66.00	06600	PHYSICAL THERAPY	3,948	3,948	0	0	634,876	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
69.00	06900	ELECTROCARDIOLOGY	8,228	8,228	368,915	0	820,031	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	935,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,738,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,132,548	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	172,500	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	5,181	5,181	149,142	0	830,350	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,223	6,223	1,074,413	0	1,913,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	299,251	299,251	15,846,219	-11,362,362	33,758,483	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	2,925	28,703	0	94,096	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	929	0	0	997	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	88,334	0	371,514	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	13,285	194.02
194.03	07953	UNUSED SPACE	14,862	14,862	0	0	165,758	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	891,750	2,654,576	3,532,108		11,362,362	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.804536	8.348590	0.221265		0.330262	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,403		464,763	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000777		0.013509	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/25/2018 5:30 pm

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/25/2018 5:30 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			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	180,902					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	409,851				8.00
9.00	00900	HOUSEKEEPING	3,382	0	175,166			9.00
10.00	01000	DIETARY	8,602	0	8,602	35,514		10.00
11.00	01100	CAFETERIA	4,191	0	4,191	0	20,844	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	0	4,673	0	1,633	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,206	6,202	9,206	0	304	14.00
15.00	01500	PHARMACY	3,393	0	3,393	0	654	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	0	9,422	0	811	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,832	128,033	32,832	15,222	4,002	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	45,773	5,363	3,040	1,736	31.00
40.00	04000	SUBPROVIDER - IPF	9,812	38,720	9,812	12,660	2,244	40.00
43.00	04300	NURSERY	1,398	0	1,398	0	363	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,065	40,842	19,065	0	2,035	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,373	370	52.00
53.00	05300	ANESTHESIOLOGY	428	0	428	0	17	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,847	35,901	12,847	0	1,475	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	8,346	2,194	8,346	0	2,148	60.00
65.00	06500	RESPIRATORY THERAPY	3,292	0	3,292	0	622	65.00
66.00	06600	PHYSICAL THERAPY	3,948	0	3,948	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
69.00	06900	ELECTROCARDIOLOGY	8,228	5,437	8,228	0	584	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	5,181	12,863	5,181	0	222	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,223	69,767	6,223	0	1,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162,186	385,732	156,450	33,295	20,661	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	0	2,925	0	83	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	24,119	929	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	100	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	1,545	0	194.02
194.03	07953	UNUSED SPACE	14,862	0	14,862	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	674	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,171,402	287,050	1,183,185	729,155	1,085,184	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.058905	0.700376	6.754650	20.531481	52.062176	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,095,748	42,877	69,800	156,271	83,549	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.057136	0.104616	0.398479	4.400265	4.008300	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/25/2018 5:30 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			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						11.00
13.00	01300	NURSING ADMINISTRATION	8,000,719					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,943,944				14.00
15.00	01500	PHARMACY	0	11,318	1,132,548			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,454	0	385,907,758		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,557,850	138,760	0	24,517,054		30.00
31.00	03100	INTENSIVE CARE UNIT	1,124,972	90,424	0	9,642,134		31.00
40.00	04000	SUBPROVIDER - IPF	1,232,901	28,166	0	15,772,384		40.00
43.00	04300	NURSERY	275,761	765	0	1,892,143		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,441,394	659,692	0	79,254,076		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	281,372	107,535	0	1,925,127		52.00
53.00	05300	ANESTHESIOLOGY	12,056	41,320	0	24,630,097		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	94,072	0	57,413,943		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	463,104	0	69,714,765		60.00
65.00	06500	RESPIRATORY THERAPY	0	36,981	0	7,117,858		65.00
66.00	06600	PHYSICAL THERAPY	0	511	0	3,321,385		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,360	0	14,942,373		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	453,111	0	5,975,828		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,613,083	0	17,474,362		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,132,548	8,755,279		73.00
74.00	07400	RENAL DIALYSIS	0	424	0	792,394		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03950	WOUND CARE	0	54,537	0	6,666,162		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,074,413	136,598	0	36,100,394		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,000,719	3,943,215	1,132,548	385,907,758		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	99	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	630	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	UNUSED SPACE	0	0	0	0		194.03
194.04	07954	GUEST MEALS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,512,770	722,200	1,326,206	1,372,594		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.314068	0.183116	1.170993	0.003557		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	113,024	168,387	75,348	180,414		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.014127	0.042695	0.066530	0.000468		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/25/2018 5:30 pm

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		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	7,791,365		7,791,365	0	7,791,365	30.00
31.00	03100	INTENSIVE CARE UNIT	3,057,084		3,057,084	0	3,057,084	31.00
40.00	04000	SUBPROVIDER - IPF	3,575,881		3,575,881	0	3,575,881	40.00
43.00	04300	NURSERY	648,223		648,223	0	648,223	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,224,576		5,224,576	0	5,224,576	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,039,841		1,039,841	0	1,039,841	52.00
53.00	05300	ANESTHESIOLOGY	233,468		233,468	0	233,468	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,865,855		3,865,855	0	3,865,855	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,715,703		3,715,703	0	3,715,703	60.00
65.00	06500	RESPIRATORY THERAPY	952,944	0	952,944	0	952,944	65.00
66.00	06600	PHYSICAL THERAPY	974,163	0	974,163	0	974,163	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
69.00	06900	ELECTROCARDIOLOGY	1,424,322		1,424,322	0	1,424,322	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,348,455		1,348,455	0	1,348,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,670,527		2,670,527	0	2,670,527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,863,935		2,863,935	0	2,863,935	73.00
74.00	07400	RENAL DIALYSIS	232,367		232,367	0	232,367	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03950	WOUND CARE	1,313,313		1,313,313	0	1,313,313	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,345,488		3,345,488	0	3,345,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	944,268		944,268		944,268	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	45,221,778	0	45,221,778	0	45,221,778	200.00
201.00		Less Observation Beds	944,268		944,268		944,268	201.00
202.00		Total (see instructions)	44,277,510	0	44,277,510	0	44,277,510	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/25/2018 5:30 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,497,559		20,497,559			30.00
31.00	03100	INTENSIVE CARE UNIT	9,642,134		9,642,134			31.00
40.00	04000	SUBPROVIDER - IPF	15,772,384		15,772,384			40.00
43.00	04300	NURSERY	1,892,143		1,892,143			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,752,782	51,501,294	79,254,076	0.065922	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,707,942	217,185	1,925,127	0.540142	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,642,695	14,987,402	24,630,097	0.009479	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,920,711	47,493,232	57,413,943	0.067333	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	16,749,721	52,965,044	69,714,765	0.053299	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,209,484	1,908,374	7,117,858	0.133881	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,168,926	152,459	3,321,385	0.293300	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
69.00	06900	ELECTROCARDIOLOGY	3,855,150	11,087,223	14,942,373	0.095321	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,666,718	2,309,110	5,975,828	0.225652	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,203,291	6,271,071	17,474,362	0.152825	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,482,424	4,272,855	8,755,279	0.327110	0.000000	73.00
74.00	07400	RENAL DIALYSIS	745,215	47,179	792,394	0.293247	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03950	WOUND CARE	12,947	6,653,215	6,666,162	0.197012	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,771,527	30,328,867	36,100,394	0.092672	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,178,192	2,841,303	4,019,495	0.234922	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	152,871,945	233,035,813	385,907,758			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	152,871,945	233,035,813	385,907,758			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/25/2018 5:30 pm

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
40.00	04000	SUBPROVIDER - IPF	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.065922
51.00	05100	RECOVERY ROOM	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.540142
53.00	05300	ANESTHESIOLOGY	0.009479
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.067333
54.01	05401	ULTRASOUND	0.000000
56.00	05600	RADIOISOTOPE	0.000000
57.00	05700	CT SCAN	0.000000
58.00	05800	MRI	0.000000
60.00	06000	LABORATORY	0.053299
65.00	06500	RESPIRATORY THERAPY	0.133881
66.00	06600	PHYSICAL THERAPY	0.293300
67.00	06700	OCCUPATIONAL THERAPY	0.000000
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.095321
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.225652
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152825
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327110
74.00	07400	RENAL DIALYSIS	0.293247
76.00	03560	OTHER ANCILLARY COSTS	0.000000
76.01	03610	SLEEP LAB	0.000000
76.03	03950	WOUND CARE	0.197012
		OUTPATIENT SERVICE COST CENTERS	
91.00	09100	EMERGENCY	0.092672
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.234922
		OTHER REIMBURSABLE COST CENTERS	
95.00	09500	AMBULANCE SERVICES	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,791,365		7,791,365	0	7,791,365	30.00
31.00	03100	INTENSIVE CARE UNIT	3,057,084		3,057,084	0	3,057,084	31.00
40.00	04000	SUBPROVIDER - IPF	3,575,881		3,575,881	0	3,575,881	40.00
43.00	04300	NURSERY	648,223		648,223	0	648,223	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,224,576		5,224,576	0	5,224,576	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,039,841		1,039,841	0	1,039,841	52.00
53.00	05300	ANESTHESIOLOGY	233,468		233,468	0	233,468	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,865,855		3,865,855	0	3,865,855	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,715,703		3,715,703	0	3,715,703	60.00
65.00	06500	RESPIRATORY THERAPY	952,944	0	952,944	0	952,944	65.00
66.00	06600	PHYSICAL THERAPY	974,163	0	974,163	0	974,163	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
69.00	06900	ELECTROCARDIOLOGY	1,424,322		1,424,322	0	1,424,322	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,348,455		1,348,455	0	1,348,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,670,527		2,670,527	0	2,670,527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,863,935		2,863,935	0	2,863,935	73.00
74.00	07400	RENAL DIALYSIS	232,367		232,367	0	232,367	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03950	WOUND CARE	1,313,313		1,313,313	0	1,313,313	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,345,488		3,345,488	0	3,345,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	944,268		944,268		944,268	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	45,221,778	0	45,221,778	0	45,221,778	200.00
201.00		Less Observation Beds	944,268		944,268		944,268	201.00
202.00		Total (see instructions)	44,277,510	0	44,277,510	0	44,277,510	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,497,559		20,497,559			30.00
31.00	03100	INTENSIVE CARE UNIT	9,642,134		9,642,134			31.00
40.00	04000	SUBPROVIDER - IPF	15,772,384		15,772,384			40.00
43.00	04300	NURSERY	1,892,143		1,892,143			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,752,782	51,501,294	79,254,076	0.065922	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,707,942	217,185	1,925,127	0.540142	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,642,695	14,987,402	24,630,097	0.009479	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,920,711	47,493,232	57,413,943	0.067333	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	16,749,721	52,965,044	69,714,765	0.053299	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,209,484	1,908,374	7,117,858	0.133881	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,168,926	152,459	3,321,385	0.293300	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
69.00	06900	ELECTROCARDIOLOGY	3,855,150	11,087,223	14,942,373	0.095321	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,666,718	2,309,110	5,975,828	0.225652	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,203,291	6,271,071	17,474,362	0.152825	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,482,424	4,272,855	8,755,279	0.327110	0.000000	73.00
74.00	07400	RENAL DIALYSIS	745,215	47,179	792,394	0.293247	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03950	WOUND CARE	12,947	6,653,215	6,666,162	0.197012	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,771,527	30,328,867	36,100,394	0.092672	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,178,192	2,841,303	4,019,495	0.234922	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	152,871,945	233,035,813	385,907,758			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	152,871,945	233,035,813	385,907,758			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | 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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.065922		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.540142		52.00
53.00	05300	ANESTHESIOLOGY	0.009479		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.067333		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.053299		60.00
65.00	06500	RESPIRATORY THERAPY	0.133881		65.00
66.00	06600	PHYSICAL THERAPY	0.293300		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.095321		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.225652		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152825		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327110		73.00
74.00	07400	RENAL DIALYSIS	0.293247		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03950	WOUND CARE	0.197012		76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.092672		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.234922		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part II Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,224,576	471,920	4,752,656	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,039,841	30,313	1,009,528	0	0	52.00
53.00	05300	ANESTHESIOLOGY	233,468	22,301	211,167	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,865,855	299,618	3,566,237	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,715,703	239,621	3,476,082	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	952,944	73,665	879,279	0	0	65.00
66.00	06600	PHYSICAL THERAPY	974,163	79,672	894,491	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
69.00	06900	ELECTROCARDIOLOGY	1,424,322	166,339	1,257,983	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,348,455	34,778	1,313,677	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,670,527	100,538	2,569,989	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,863,935	94,745	2,769,190	0	0	73.00
74.00	07400	RENAL DIALYSIS	232,367	2,719	229,648	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	1,313,313	110,248	1,203,065	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,345,488	187,242	3,158,246	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	944,268	94,985	849,283	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	30,149,225	2,008,704	28,140,521	0	0	200.00
201.00		Less Observation Beds	944,268	94,985	849,283	0	0	201.00
202.00		Total (line 200 minus line 201)	29,204,957	1,913,719	27,291,238	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part II Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,224,576	79,254,076	0.065922		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,039,841	1,925,127	0.540142		52.00
53.00	05300	ANESTHESIOLOGY	233,468	24,630,097	0.009479		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,865,855	57,413,943	0.067333		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	3,715,703	69,714,765	0.053299		60.00
65.00	06500	RESPIRATORY THERAPY	952,944	7,117,858	0.133881		65.00
66.00	06600	PHYSICAL THERAPY	974,163	3,321,385	0.293300		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	1,424,322	14,942,373	0.095321		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,348,455	5,975,828	0.225652		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,670,527	17,474,362	0.152825		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,863,935	8,755,279	0.327110		73.00
74.00	07400	RENAL DIALYSIS	232,367	792,394	0.293247		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	0	0	0.000000		76.01
76.03	03950	WOUND CARE	1,313,313	6,666,162	0.197012		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,345,488	36,100,394	0.092672		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	944,268	4,019,495	0.234922		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
200.00		Subtotal (sum of lines 50 thru 199)	30,149,225	338,103,538			200.00
201.00		Less Observation Beds	944,268	0			201.00
202.00		Total (line 200 minus line 201)	29,204,957	338,103,538			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part I Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	783,744	0	783,744	6,832	114.72	30.00
31.00	INTENSIVE CARE UNIT	168,139		168,139	1,377	122.11	31.00
40.00	SUBPROVIDER - IPF	293,176	0	293,176	4,236	69.21	40.00
43.00	NURSERY	36,119		36,119	758	47.65	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,281,178		1,281,178	13,203		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	2,917	334,638		30.00
31.00	INTENSIVE CARE UNIT	727	88,774		31.00
40.00	SUBPROVIDER - IPF	3,292	227,839		40.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30 through 199)	6,936	651,251		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part II Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	471,920	79,254,076	0.005955	11,584,466	68,985	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,313	1,925,127	0.015746	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,301	24,630,097	0.000905	3,827,901	3,464	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	299,618	57,413,943	0.005219	5,046,646	26,338	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	239,621	69,714,765	0.003437	7,087,288	24,359	60.00
65.00	06500	RESPIRATORY THERAPY	73,665	7,117,858	0.010349	2,642,472	27,347	65.00
66.00	06600	PHYSICAL THERAPY	79,672	3,321,385	0.023988	1,308,174	31,380	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
69.00	06900	ELECTROCARDIOLOGY	166,339	14,942,373	0.011132	2,159,006	24,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,778	5,975,828	0.005820	2,078,613	12,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,538	17,474,362	0.005753	5,154,548	29,654	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,745	8,755,279	0.010821	1,718,013	18,591	73.00
74.00	07400	RENAL DIALYSIS	2,719	792,394	0.003431	313,281	1,075	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950	WOUND CARE	110,248	6,666,162	0.016538	12,167	201	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	187,242	36,100,394	0.005187	2,861,250	14,841	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	94,985	4,019,495	0.023631	578,085	13,661	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,008,704	338,103,538		46,371,910	296,028	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part III Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,832	0.00	2,917	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,377	0.00	727	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,236	0.00	3,292	40.00
43.00	04300	NURSERY		0	758	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	13,203		6,936	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	79,254,076	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,925,127	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	24,630,097	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	57,413,943	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	69,714,765	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,117,858	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,321,385	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,942,373	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,975,828	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,474,362	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,755,279	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	792,394	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	6,666,162	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	36,100,394	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,019,495	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	338,103,538		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	11,584,466	0	17,163,425	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,827,901	0	4,806,301	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,046,646	0	13,400,946	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	7,087,288	0	4,202,211	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,642,472	0	414,357	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,308,174	0	28,000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,159,006	0	4,542,694	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,078,613	0	502,528	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,154,548	0	3,151,939	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,718,013	0	1,492,712	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	313,281	0	8,183	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	12,167	0	3,017,393	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	2,861,250	0	5,529,495	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	578,085	0	857,995	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		46,371,910	0	59,118,179	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.065922	17,163,425	0	0	1,131,447	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.540142	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.009479	4,806,301	0	0	45,559	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.067333	13,400,946	0	0	902,326	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.053299	4,202,211	0	0	223,974	60.00
65.00	06500	RESPIRATORY THERAPY	0.133881	414,357	0	0	55,475	65.00
66.00	06600	PHYSICAL THERAPY	0.293300	28,000	0	0	8,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.095321	4,542,694	0	0	433,014	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.225652	502,528	0	0	113,396	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152825	3,151,939	0	0	481,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327110	1,492,712	14,533	0	488,281	73.00
74.00	07400	RENAL DIALYSIS	0.293247	8,183	0	0	2,400	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.197012	3,017,393	0	0	594,463	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.092672	5,529,495	0	0	512,429	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.234922	857,995	0	0	201,562	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		59,118,179	14,533	0	5,194,233	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		59,118,179	14,533	0	5,194,233	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,754	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03950	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,754	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,754	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0040 | Component CCN: 14-S040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part II Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	471,920	79,254,076	0.005955	6,441	38	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,313	1,925,127	0.015746	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,301	24,630,097	0.000905	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	299,618	57,413,943	0.005219	509,370	2,658	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	239,621	69,714,765	0.003437	1,728,384	5,940	60.00
65.00	06500	RESPIRATORY THERAPY	73,665	7,117,858	0.010349	423,670	4,385	65.00
66.00	06600	PHYSICAL THERAPY	79,672	3,321,385	0.023988	549,944	13,192	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
69.00	06900	ELECTROCARDIOLOGY	166,339	14,942,373	0.011132	135,179	1,505	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,778	5,975,828	0.005820	10,416	61	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,538	17,474,362	0.005753	1,215	7	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,745	8,755,279	0.010821	749,448	8,110	73.00
74.00	07400	RENAL DIALYSIS	2,719	792,394	0.003431	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950	WOUND CARE	110,248	6,666,162	0.016538	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	187,242	36,100,394	0.005187	329,572	1,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,019,495	0.000000	3,300	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,913,719	338,103,538		4,446,939	37,605	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Component CCN: 14-S040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Component CCN: 14-S040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	79,254,076	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,925,127	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	24,630,097	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	57,413,943	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	69,714,765	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,117,858	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,321,385	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,942,373	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,975,828	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,474,362	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,755,279	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	792,394	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	6,666,162	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	36,100,394	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,019,495	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	338,103,538		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Component CCN: 14-S040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	6,441	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	509,370	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,728,384	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	423,670	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	549,944	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	135,179	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	10,416	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,215	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	749,448	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	329,572	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,300	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,446,939	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Component CCN: 14-5690 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040
Component CCN: 14-5690

Period: From 05/01/2017 To 04/30/2018

Worksheet D Part IV Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	79,254,076	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,925,127	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	24,630,097	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	57,413,943	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	69,714,765	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,117,858	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,321,385	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,942,373	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,975,828	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,474,362	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,755,279	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	792,394	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	6,666,162	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	36,100,394	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,019,495	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	338,103,538		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Component CCN: 14-5690 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part I Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	783,744	0	783,744	6,832	114.72	30.00
31.00	INTENSIVE CARE UNIT	168,139		168,139	1,377	122.11	31.00
40.00	SUBPROVIDER - IPF	293,176	0	293,176	4,236	69.21	40.00
43.00	NURSERY	36,119		36,119	758	47.65	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,281,178		1,281,178	13,203		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	271	31,089	30.00
31.00	INTENSIVE CARE UNIT	70	8,548	31.00
40.00	SUBPROVIDER - IPF	74	5,122	40.00
43.00	NURSERY	250	11,913	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	665	56,672	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part II Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	471,920	79,254,076	0.005955	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,313	1,925,127	0.015746	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,301	24,630,097	0.000905	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	299,618	57,413,943	0.005219	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	239,621	69,714,765	0.003437	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	73,665	7,117,858	0.010349	0	0	65.00
66.00	06600	PHYSICAL THERAPY	79,672	3,321,385	0.023988	0	0	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
69.00	06900	ELECTROCARDIOLOGY	166,339	14,942,373	0.011132	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,778	5,975,828	0.005820	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,538	17,474,362	0.005753	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,745	8,755,279	0.010821	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,719	792,394	0.003431	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950	WOUND CARE	110,248	6,666,162	0.016538	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	187,242	36,100,394	0.005187	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	94,985	4,019,495	0.023631	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,008,704	338,103,538		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part III Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,832	0.00	271	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,377	0.00	70	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,236	0.00	74	40.00
43.00	04300	NURSERY		0	758	0.00	250	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	13,203		665	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	79,254,076	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,925,127	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	24,630,097	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	57,413,943	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	69,714,765	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,117,858	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,321,385	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,942,373	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,975,828	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,474,362	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,755,279	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	792,394	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	6,666,162	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	36,100,394	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,019,495	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	338,103,538		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,832	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,832	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)	6,004	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)	2,917	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)	7,791,365	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)	7,791,365	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)	7,791,365	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)	1,140.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,326,605	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)	3,326,605	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,057,084	1,377	2,220.10	727	1,614,013	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)	4,774,765	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,715,383	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)	423,412	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	296,028	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	719,440	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,995,943	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)	828	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,140.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	944,268	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	783,744	7,791,365	0.100591	944,268	94,985	90.00
91.00	Nursing School cost	0	7,791,365	0.000000	944,268	0	91.00
92.00	Allied health cost	0	7,791,365	0.000000	944,268	0	92.00
93.00	All other Medical Education	0	7,791,365	0.000000	944,268	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040 | Component CCN: 14-S040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,236	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,236	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,236	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)	3,292	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)	3,575,881	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)	3,575,881	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)	3,575,881	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)	844.16	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,778,975	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,778,975	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040 | Component CCN: 14-S040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)	636,753	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,415,728	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)	227,839	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	37,605	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	265,444	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,150,284	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: 14-0040 | Component CCN: 14-S040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	293,176	3,575,881	0.081987	0	0	90.00
91.00	Nursing School cost	0	3,575,881	0.000000	0	0	91.00
92.00	Allied health cost	0	3,575,881	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,575,881	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0040 Component CCN: 14-5690	Period: From 05/01/2017 To 04/30/2018	Worksheet D-1 Date/Time Prepared: 9/25/2018 5:30 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	0	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)	0	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)	0	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)	0	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)	0	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)	0	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040 | Component CCN: 14-5690 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	0	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0.00	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	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: 14-0040
Component CCN: 14-5690

Period:
From 05/01/2017
To 04/30/2018

Worksheet D-1
Date/Time Prepared:
9/25/2018 5:30 pm

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,832	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,832	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)	6,004	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)	271	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)	758	15.00
16.00	Nursery days (title V or XIX only)	250	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)	7,791,365	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)	7,791,365	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)	7,791,365	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)	1,140.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	309,054	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)	309,054	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	648,223	758	855.18	250	213,795	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,057,084	1,377	2,220.10	70	155,407	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	678,256	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)	51,550	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)	51,550	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	626,706	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)	828	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,140.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	944,268	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	783,744	7,791,365	0.100591	944,268	94,985	90.00
91.00	Nursing School cost	0	7,791,365	0.000000	944,268	0	91.00
92.00	Allied health cost	0	7,791,365	0.000000	944,268	0	92.00
93.00	All other Medical Education	0	7,791,365	0.000000	944,268	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-3 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,692,199		30.00
31.00	03100	INTENSIVE CARE UNIT		5,099,816		31.00
40.00	04000	SUBPROVIDER - IPF		42,870		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.065922	11,584,466	763,671	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.540142	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.009479	3,827,901	36,285	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.067333	5,046,646	339,806	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.053299	7,087,288	377,745	60.00
65.00	06500	RESPIRATORY THERAPY	0.133881	2,642,472	353,777	65.00
66.00	06600	PHYSICAL THERAPY	0.293300	1,308,174	383,687	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.095321	2,159,006	205,799	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.225652	2,078,613	469,043	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152825	5,154,548	787,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327110	1,718,013	561,979	73.00
74.00	07400	RENAL DIALYSIS	0.293247	313,281	91,869	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03950	WOUND CARE	0.197012	12,167	2,397	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.092672	2,861,250	265,158	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.234922	578,085	135,805	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		46,371,910	4,774,765	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)		46,371,910		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0040 | Component CCN: 14-S040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-3 | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		10,279,204		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.065922	6,441	425	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.540142	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.009479	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.067333	509,370	34,297	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.053299	1,728,384	92,121	60.00
65.00	06500	RESPIRATORY THERAPY	0.133881	423,670	56,721	65.00
66.00	06600	PHYSICAL THERAPY	0.293300	549,944	161,299	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.095321	135,179	12,885	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.225652	10,416	2,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.152825	1,215	186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.327110	749,448	245,152	73.00
74.00	07400	RENAL DIALYSIS	0.293247	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03950	WOUND CARE	0.197012	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.092672	329,572	30,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.234922	3,300	775	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,446,939	636,753	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)		4,446,939		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0040	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part A Date/Time Prepared: 9/25/2018 5:30 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,319,936	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,823,543	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	152,041	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	120.73	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.88	30.00
31.00	Percentage of Medicaid patient days (see instructions)	25.49	31.00
32.00	Sum of lines 30 and 31	30.37	32.00
33.00	Allowable disproportionate share percentage (see instructions)	14.27	33.00
34.00	Disproportionate share adjustment (see instructions)	219,169	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E Part A Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	450,381	351,860	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	188,790	204,368	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	393,158		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,907,847		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	7,175,115		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		7,108,298	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		522,032	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		7,630,330	59.00
60.00	Primary payer payments		3,838	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		7,626,492	61.00
62.00	Deductibles billed to program beneficiaries		799,616	62.00
63.00	Coinsurance billed to program beneficiaries		11,844	63.00
64.00	Allowable bad debts (see instructions)		244,703	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		159,057	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		219,163	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,974,089	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		-478	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-2,743	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-15,626	70.93
70.94	HRR adjustment amount (see instructions)		-83,727	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0040	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part A Date/Time Prepared: 9/25/2018 5:30 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2017	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2018	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,871,515	71.00
71.01	Sequestration adjustment (see instructions)		137,430	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		6,905,241	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-171,156	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,621,685	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	84,025	116,426	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.9998623160	0.9959962314	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	-12	-466	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9855	0.9869	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-1,218	-1,525	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,319,936	0	2,319,936		2,319,936	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,823,543	0		3,823,543	3,823,543	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	152,041	0	1,615	150,426	152,041	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1427	0.1427	0.1427	0.1427		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	219,169	0	82,764	136,405	219,169	11.00
11.01	Uncompensated care payments	36.00	393,158	0	188,790	204,368	393,158	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,907,847	0	2,593,105	4,314,742	6,907,847	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,175,115	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,108,298	0	2,593,105	4,515,193	7,108,298	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	522,032	0	218,824	303,208	522,032	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	2,811,929	4,818,401	7,630,330	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	495,463	0	207,687	287,776	495,463	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	26,569	0	11,137	15,432	26,569	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	522,032	0	218,824	303,208	522,032	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.040357	0.069286		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			113,481		113,481	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				333,848	333,848	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0040	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part B Date/Time Prepared: 9/25/2018 5:30 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,754	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,194,233	2.00
3.00	OPPS payments	4,664,647	3.00
4.00	Outlier payment (see instructions)	59,915	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,754	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	14,533	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	14,533	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	14,533	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	9,779	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	4,754	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	4,724,562	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	4,952	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	906,168	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,818,196	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,818,196	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,818,196	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	183,532	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	119,296	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	166,658	36.00
37.00	Subtotal (see instructions)	3,937,492	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,937,492	40.00
40.01	Sequestration adjustment (see instructions)	78,750	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,843,411	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	15,331	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 9/25/2018 5:30 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		6,905,241		3,843,411	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,905,241		3,843,411	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		15,331	6.01
6.02	SETTLEMENT TO PROGRAM		171,156		0	6.02
7.00	Total Medicare program liability (see instructions)		6,734,085		3,858,742	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0040 | Component CCN: 14-S040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 9/25/2018 5:30 pm

Title XVIII | Subprovider - IPF | 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		3,016,996		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,016,996		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		28,577		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,045,573		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0040	Period: From 05/01/2017 To 04/30/2018	Worksheet E-1 Part II Date/Time Prepared: 9/25/2018 5:30 pm
	Title XVIII	Hospital	PPS

			1.00
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0040 Component CCN: 14-S040	Period: From 05/01/2017 To 04/30/2018	Worksheet E-3 Part II Date/Time Prepared: 9/25/2018 5:30 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	3,181,099	1.00
2.00	Net IPF PPS Outlier Payments	94,320	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	11.605479	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	3,275,419	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	3,275,419	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	3,275,419	18.00
19.00	Deductibles	154,692	19.00
20.00	Subtotal (line 18 minus line 19)	3,120,727	20.00
21.00	Coinsurance	44,200	21.00
22.00	Subtotal (line 20 minus line 21)	3,076,527	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	48,001	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	31,201	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	43,602	25.00
26.00	Subtotal (sum of lines 22 and 24)	3,107,728	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	3,107,728	31.00
31.01	Sequestration adjustment (see instructions)	62,155	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	3,016,996	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	28,577	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	94,320	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	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0040 Component CCN: 14-5690	Period: From 05/01/2017 To 04/30/2018	Worksheet E-3 Part VI Date/Time Prepared: 9/25/2018 5:30 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	0	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	0	7.00
8.00	Allowable bad debts (see instructions)	7,850	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	5,103	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	5,103	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	5,103	15.00
15.01	Sequestration adjustment (see instructions)	102	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	0	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	5,001	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

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

Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G | Date/Time Prepared: 9/25/2018 5:30 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	-570,037	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	12,994,391	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,206,141	0	0	0	6.00
7.00	Inventory	1,669,649	0	0	0	7.00
8.00	Prepaid expenses	735,631	0	0	0	8.00
9.00	Other current assets	87,508	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,711,001	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	259,268	0	0	0	12.00
13.00	Land improvements	554,380	0	0	0	13.00
14.00	Accumulated depreciation	-483,552	0	0	0	14.00
15.00	Buildings	15,726,371	0	0	0	15.00
16.00	Accumulated depreciation	-7,237,388	0	0	0	16.00
17.00	Leasehold improvements	15,234,910	0	0	0	17.00
18.00	Accumulated depreciation	-6,536,674	0	0	0	18.00
19.00	Fixed equipment	4,211,473	0	0	0	19.00
20.00	Accumulated depreciation	-2,127,650	0	0	0	20.00
21.00	Automobiles and trucks	30,160	0	0	0	21.00
22.00	Accumulated depreciation	-30,160	0	0	0	22.00
23.00	Major movable equipment	13,373,802	0	0	0	23.00
24.00	Accumulated depreciation	-10,887,426	0	0	0	24.00
25.00	Minor equipment depreciable	5,643,601	0	0	0	25.00
26.00	Accumulated depreciation	-5,217,287	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)	22,513,828	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	1,851,660	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,851,660	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,076,489	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,934,528	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,311,717	0	0	0	38.00
39.00	Payroll taxes payable	168,082	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-11,270,511	0	0	0	43.00
44.00	Other current liabilities	1,932,343	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-5,923,841	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-5,923,841	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	44,000,330				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	44,000,330	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,076,489	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G-1 | Date/Time Prepared: 9/25/2018 5:30 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		37,681,080		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,319,250				2.00
3.00	Total (sum of line 1 and line 2)		44,000,330		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		44,000,330		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		44,000,330		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/25/2018 5:30 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,389,702		22,389,702	1.00
2.00	SUBPROVIDER - IPF	15,772,384		15,772,384	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)	38,162,086		38,162,086	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,642,134		9,642,134	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)	9,642,134		9,642,134	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	47,804,220		47,804,220	17.00
18.00	Ancillary services	98,114,006	199,869,643	297,983,649	18.00
19.00	Outpatient services	6,949,719	33,170,170	40,119,889	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)	152,867,945	233,039,813	385,907,758	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		55,164,854		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)		55,164,854		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0040 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G-3 | Date/Time Prepared: 9/25/2018 5:30 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	385,907,758	1.00
2.00	Less contractual allowances and discounts on patients' accounts	324,397,373	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,510,385	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	55,164,854	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,345,531	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	-26,277	24.00
25.00	Total other income (sum of lines 6-24)	-26,277	25.00
26.00	Total (line 5 plus line 25)	6,319,254	26.00
27.00	ROUNDING	4	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,319,250	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0040	Period: From 05/01/2017 To 04/30/2018	Worksheet L Parts I-III Date/Time Prepared: 9/25/2018 5:30 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	495,463	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	26,569	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	20.27	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	522,032	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00