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: 14-1312	Period: From 05/01/2017 To 04/30/2018	Worksheet S Parts I-III Date/Time Prepared: 8/16/2018 9:26 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/16/2018 Time: 9:26 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 ROCHELLE COMMUNITY HOSPITAL (14-1312) 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.

[X] 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) LORI GUTIERREZ
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
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	-102,477	-8,387	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	2,018	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-100,459	-8,387	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/16/2018 9:23 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 900 NORTH 2ND STREET	PO Box:			1.00
2.00	City: ROCHELLE	State: IL	Zip Code: 61068	County: OGLE	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	ROCHELLE COMMUNITY HOSPITAL	141312	99914	1	05/01/2001	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ROCHELLE COMMUNITY HOSPITAL	14Z312	99914		04/17/1987	N	N	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
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)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 8/16/2018 9:23 am

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

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		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: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/16/2018 9:23 am

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 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)			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: 14-1312	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part I Date/Time Prepared: 8/16/2018 9:23 am

		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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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		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.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	227,092	9,846	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)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/16/2018 9:23 am

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			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)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	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)	10/01/2016	09/30/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 8/16/2018 9:23 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/30/2018	Y	05/30/2018	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: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 8/16/2018 9:23 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					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.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					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.	KEVIN		WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4389		KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1312	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part II Date/Time Prepared: 8/16/2018 9:23 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 8/16/2018 9:23 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	13	4,745	30,674.64	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)		13	4,745	30,674.64	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		17	6,205	30,674.64	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		17				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: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/16/2018 9:23 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	726	101	1,241			1.00
2.00	HMO and other (see instructions)	112	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	67	0	67			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	7			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	793	101	1,315			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	793	101	1,315	0.00	286.65	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	286.65	27.00
28.00	Observation Bed Days		0	451			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/16/2018 9:23 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	240	39	425	1.00
2.00	HMO and other (see instructions)			36	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	240	39	425	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-10 | Date/Time Prepared: 8/16/2018 9:23 am

		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)	0.395462	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,959,547	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	1,234,203	5.00
6.00	Medicaid charges	7,664,033	6.00
7.00	Medicaid cost (line 1 times line 6)	3,030,834	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	203	9.00
10.00	Stand-alone CHIP charges	309	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	122	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	15,276	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,159,940	63,695	1,223,635	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	458,712	63,695	522,407	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	458,712	63,695	522,407	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)	1,808,948	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	586,086	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	901,670	27.01
28.00	Non-Medicare bad debt expense (see instructions)	907,278	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	674,378	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,196,785	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,196,785	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,056,890	1,056,890	598,736	1,655,626	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,287,769	1,287,769	-291,348	996,421	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	176,449	3,948,890	4,125,339	0	4,125,339	4.00
5.01	00570	ADMITTING	340,707	19,854	360,561	119,978	480,539	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	502,452	318,561	821,013	0	821,013	5.02
5.03	00590	OTHER ADMIN & GENERAL	1,457,679	1,987,714	3,445,393	50,480	3,495,873	5.03
7.00	00700	OPERATION OF PLANT	368,395	908,214	1,276,609	0	1,276,609	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	66,278	66,278	8.00
9.00	00900	HOUSEKEEPING	339,414	106,400	445,814	-63,587	382,227	9.00
10.00	01000	DIETARY	281,199	245,079	526,278	-350,133	176,145	10.00
11.00	01100	CAFETERIA	0	0	0	350,133	350,133	11.00
13.00	01300	NURSING ADMINISTRATION	251,917	84,562	336,479	0	336,479	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	136,517	25,099	161,616	-2,691	158,925	14.00
15.00	01500	PHARMACY	188,194	1,574,693	1,762,887	0	1,762,887	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	478,542	129,640	608,182	0	608,182	16.00
17.00	01700	SOCIAL SERVICE	216,048	23,300	239,348	0	239,348	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,627,168	144,928	1,772,096	0	1,772,096	30.00
31.00	03100	INTENSIVE CARE UNIT	0	14,214	14,214	0	14,214	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	858,558	603,984	1,462,542	0	1,462,542	50.00
53.00	05300	ANESTHESIOLOGY	0	240,921	240,921	0	240,921	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	649,801	1,645,942	2,295,743	0	2,295,743	54.00
60.00	06000	LABORATORY	723,005	1,178,988	1,901,993	-9,014	1,892,979	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	65,369	65,369	10,947	76,316	62.00
64.00	06400	INTRAVENOUS THERAPY	231,187	18,446	249,633	0	249,633	64.00
65.00	06500	RESPIRATORY THERAPY	12,322	936,386	948,708	-56,008	892,700	65.00
66.00	06600	PHYSICAL THERAPY	0	719,105	719,105	-104,870	614,235	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	104,870	104,870	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,491	9,491	0	9,491	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	128,541	128,541	0	128,541	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	43,843	3,328	47,171	0	47,171	90.01
91.00	09100	EMERGENCY	1,346,791	1,441,899	2,788,690	-1,933	2,786,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		242,414	242,414	-242,414	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,230,188	19,110,621	29,340,809	179,424	29,520,233	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	285,342	140,384	425,726	0	425,726	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	172,773	2,844	175,617	-175,617	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	1,438,689	300,121	1,738,810	-3,807	1,735,003	194.03
194.04	07954	340B PHARMACY	0	10,147	10,147	0	10,147	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	12,126,992	19,564,117	31,691,109	0	31,691,109	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-169,638	1,485,988		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-136,845	859,576		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-22,686	4,102,653		4.00
5.01	00570	ADMITTING	0	480,539		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	821,013		5.02
5.03	00590	OTHER ADMIN & GENERAL	-919,566	2,576,307		5.03
7.00	00700	OPERATION OF PLANT	-579	1,276,030		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,278		8.00
9.00	00900	HOUSEKEEPING	0	382,227		9.00
10.00	01000	DIETARY	0	176,145		10.00
11.00	01100	CAFETERIA	-115,988	234,145		11.00
13.00	01300	NURSING ADMINISTRATION	-3,591	332,888		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	158,925		14.00
15.00	01500	PHARMACY	0	1,762,887		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,781	600,401		16.00
17.00	01700	SOCIAL SERVICE	0	239,348		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,772,096		30.00
31.00	03100	INTENSIVE CARE UNIT	0	14,214		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-22,500	1,440,042		50.00
53.00	05300	ANESTHESIOLOGY	-240,466	455		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,295,743		54.00
60.00	06000	LABORATORY	0	1,892,979		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	76,316		62.00
64.00	06400	INTRAVENOUS THERAPY	-500	249,133		64.00
65.00	06500	RESPIRATORY THERAPY	0	892,700		65.00
66.00	06600	PHYSICAL THERAPY	-63,033	551,202		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	104,870		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,491		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	128,541		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	DIABETIC SERVICES	0	47,171		90.01
91.00	09100	EMERGENCY	-1,148,669	1,638,088		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,851,842	26,668,391		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	425,726		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	0		194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	1,735,003		194.03
194.04	07954	340B PHARMACY	0	10,147		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,851,842	28,839,267		200.00

RECLASSIFICATIONS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-6 | Date/Time Prepared: 8/16/2018 9:23 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	64,974		1.00
	0		0	64,974		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	187,082	163,051		1.00
	0		187,082	163,051		
	C - RECEPTIONIST-NURSING					
1.00	ADMITTING	5.01	118,035	1,943		1.00
2.00	RESPIRATORY THERAPY	65.00	54,738	901		2.00
	0		172,773	2,844		
	D - FITNESS CENTER					
1.00	OTHER ADMIN & GENERAL	5.03	0	111,647		1.00
	0		0	111,647		
	E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	242,414		1.00
	0		0	242,414		
	F - EKGS					
1.00	LABORATORY	60.00	1,933	0		1.00
	0		1,933	0		
	G - FIXED EQUIPMENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	311,979		1.00
	0		0	311,979		
	H - THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	0	104,870		1.00
	0		0	104,870		
	I - LAUNDRY AND LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	66,278		1.00
2.00		0.00	0	0		2.00
	0		0	66,278		
	J - PHYSICIAN ADMIN COSTS					
1.00	OTHER ADMIN & GENERAL	5.03	3,807	0		1.00
	0		3,807	0		
	K - BLOOD BANK SALARIES					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	10,947	0		1.00
	0		10,947	0		
500.00	Grand Total: Increases		376,542	1,068,057		500.00

RECLASSIFICATIONS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-6 | Date/Time Prepared: 8/16/2018 9:23 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.03	0	64,974	12		1.00
	0		0	64,974			
	B - CAFETERIA						
1.00	DIETARY	10.00	187,082	163,051	0		1.00
	0		187,082	163,051			
	C - RECEPTIONIST-NURSING						
1.00	PHYSICIANS CLINICS	194.02	172,773	2,844	0		1.00
2.00		0.00	0	0	0		2.00
	0		172,773	2,844			
	D - FITNESS CENTER						
1.00	RESPIRATORY THERAPY	65.00	0	111,647	0		1.00
	0		0	111,647			
	E - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	242,414	11		1.00
	0		0	242,414			
	F - EKGS						
1.00	EMERGENCY	91.00	1,933	0	0		1.00
	0		1,933	0			
	G - FIXED EQUIPMENT						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	311,979	9		1.00
	0		0	311,979			
	H - THERAPY						
1.00	PHYSICAL THERAPY	66.00	0	104,870	0		1.00
	0		0	104,870			
	I - LAUNDRY AND LINEN						
1.00	HOUSEKEEPING	9.00	0	63,587	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,691	0		2.00
	0		0	66,278			
	J - PHYSICIAN ADMIN COSTS						
1.00	HEALTH & WELLNESS CENTER	194.03	3,807	0	0		1.00
	0		3,807	0			
	K - BLOOD BANK SALARIES						
1.00	LABORATORY	60.00	10,947	0	0		1.00
	0		10,947	0			
500.00	Grand Total: Decreases		376,542	1,068,057			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 8/16/2018 9:23 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,389,097	0	0	0	0	1.00
2.00	Land Improvements	1,449,503	333,390	0	333,390	17,777	2.00
3.00	Buildings and Fixtures	20,216,752	690,632	0	690,632	141,562	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,578,220	446,184	0	446,184	5,060	5.00
6.00	Movable Equipment	8,619,123	1,120,168	0	1,120,168	142,892	6.00
7.00	HIT designated Assets	3,991,023	0	0	0	122,911	7.00
8.00	Subtotal (sum of lines 1-7)	40,243,718	2,590,374	0	2,590,374	430,202	8.00
9.00	Reconciling Items	-329,993	0	0	0	-329,993	9.00
10.00	Total (line 8 minus line 9)	40,573,711	2,590,374	0	2,590,374	760,195	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,389,097	0	1.00
2.00	Land Improvements	1,765,116	0	2.00
3.00	Buildings and Fixtures	20,765,822	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,019,344	0	5.00
6.00	Movable Equipment	9,596,399	0	6.00
7.00	HIT designated Assets	3,868,112	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,403,890	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	42,403,890	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 8/16/2018 9:23 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,039,789	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,287,769	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,327,558	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	17,101	1,056,890	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,287,769	2.00
3.00	Total (sum of lines 1-2)	17,101	2,344,659	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 8/16/2018 9:23 am

	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	28,939,379	0	28,939,379	0.682470	44,343	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,464,511	0	13,464,511	0.317530	20,631	2.00
3.00	Total (sum of lines 1-2)	42,403,890	0	42,403,890	1.000000	64,974	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	44,343	1,351,768	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	20,631	838,945	0	2.00
3.00	Total (sum of lines 1-2)	0	0	64,974	2,190,713	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	72,776	44,343	0	17,101	1,485,988	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,631	0	0	859,576	2.00
3.00	Total (sum of lines 1-2)	72,776	64,974	0	17,101	2,345,564	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8 | Date/Time Prepared: 8/16/2018 9:23 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-169,638	CAP REL COSTS-BLDG & FIXT	1.00	11	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	-579	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,412,135			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-115,988	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,781	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-135,676	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8 | Date/Time Prepared: 8/16/2018 9:23 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	CREDENTIALING	B	-12,600	OTHER ADMIN & GENERAL	5.03	0	33.01
33.02	MISC REVENUE	B	-39,579	OTHER ADMIN & GENERAL	5.03	0	33.02
33.03	FITNESS CENTER	B	-67,618	OTHER ADMIN & GENERAL	5.03	0	33.03
33.04	MARKETING EXPENSE	A	-228,253	OTHER ADMIN & GENERAL	5.03	0	33.04
33.05	LOBBYING EXPENSE	A	-12,330	OTHER ADMIN & GENERAL	5.03	0	33.05
33.06	PROPERTY TAX	A	5,474	OTHER ADMIN & GENERAL	5.03	0	33.06
33.07	ASSESSMENT TAX	A	-560,462	OTHER ADMIN & GENERAL	5.03	0	33.07
33.08	PHYSICIAN BENEFITS	A	-10,396	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.10	TELEPHONE SERVICES	A	-802	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	TELEPHONE SERVICES	A	-2,618	OTHER ADMIN & GENERAL	5.03	0	33.11
33.12	TELEPHONE SERVICES	A	-1,169	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.13	MARKETING BENEFITS	A	-10,696	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	MISC REVENUE - DEF COMP	B	-792	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.17	EDUCATION MISC REVENUE	B	-3,591	NURSING ADMINISTRATION	13.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	PHYSICAL THERAPY RENTAL INCOME	B	-63,033	PHYSICAL THERAPY	66.00	0	33.19
33.20	DONATIONS	A	-1,580	OTHER ADMIN & GENERAL	5.03	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,851,842				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 8/16/2018 9:23 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	22,500	22,500	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	240,466	240,466	0	0	0	2.00
3.00	64.00	INTRAVENOUS THERAPY	500	500	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	6,000	0	6,000	0	0	4.00
5.00	91.00	EMERGENCY	668,217	458,597	209,620	0	0	5.00
6.00	91.00	EMERGENCY	47,871	0	47,871	0	0	6.00
7.00	91.00	EMERGENCY	18,233	18,233	0	0	0	7.00
8.00	91.00	EMERGENCY	671,839	671,839	0	0	0	8.00
9.00	5.03	OTHER ADMIN & GENERAL	3,807	0	3,807	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,679,433	1,412,135	267,298		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	64.00	INTRAVENOUS THERAPY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	5.03	OTHER ADMIN & GENERAL	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	22,500		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	240,466		2.00
3.00	64.00	INTRAVENOUS THERAPY	0	0	0	500		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	458,597		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	91.00	EMERGENCY	0	0	0	18,233		7.00
8.00	91.00	EMERGENCY	0	0	0	671,839		8.00
9.00	5.03	OTHER ADMIN & GENERAL	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,412,135		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/16/2018 9:23 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.38	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	400.00	8,405.75	0.00	2,603.63	0.00	9.00
10.00	AHSEA (see instructions)	93.37	81.19	0.00	16.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.60	40.60	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					37,348	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					682,463	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					719,811	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					41,658	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					761,469	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					761,469	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					14,819	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					14,819	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,964	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,783	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,783	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/16/2018 9:23 am

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.19	0.00	16.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	761,469		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	16,783		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	778,252		63.00
64.00	Total cost of outside supplier services (from your records)	568,711		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	14,819		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,964		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	16,783		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,964		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,964		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1312	Period: From 05/01/2017 To 04/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/16/2018 9:23 am

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.38	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	14,449.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	63.75	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	31.88	31.88	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	921,156	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	921,156	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	921,156	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	921,156	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	11,636	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	11,636	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,964	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	13,600	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	13,600	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1312	Period: From 05/01/2017 To 04/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/16/2018 9:23 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	63.75	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	921,156	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	13,600	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	934,756	63.00
64.00	Total cost of outside supplier services (from your records)	774,737	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	11,636	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,964	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	13,600	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,964	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,964	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/16/2018 9:23 am

		Occupational Therapy	Cost
			1.00
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.38	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,101.66	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.94	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.47	38.47	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	84,762	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	84,762	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	84,762	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	84,762	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	14,042	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	14,042	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,964	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	16,006	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	16,006	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1312	Period: From 05/01/2017 To 04/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/16/2018 9:23 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.94	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	84,762	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	16,006	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	100,768	63.00
64.00	Total cost of outside supplier services (from your records)	97,129	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	14,042	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,964	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	16,006	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,964	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,964	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,485,988	1,485,988				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	859,576		859,576			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,102,653	4,639	305	4,107,597		4.00
5.01	00570	ADMITTING	480,539	8,832	1,735	160,670	651,776	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	821,013	39,267	2,587	175,979	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	2,576,307	365,345	176,963	491,170	0	5.03
7.00	00700	OPERATION OF PLANT	1,276,030	131,466	15,399	129,027	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	66,278	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	382,227	8,772	1,716	118,876	0	9.00
10.00	01000	DIETARY	176,145	33,469	2,265	32,964	0	10.00
11.00	01100	CAFETERIA	234,145	21,291	0	65,524	0	11.00
13.00	01300	NURSING ADMINISTRATION	332,888	16,935	1,618	88,231	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	158,925	14,660	1,089	47,814	0	14.00
15.00	01500	PHARMACY	1,762,887	10,824	11,442	65,913	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	600,401	21,054	3,418	167,605	0	16.00
17.00	01700	SOCIAL SERVICE	239,348	2,275	0	75,669	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,772,096	123,348	140,160	569,894	33,444	30.00
31.00	03100	INTENSIVE CARE UNIT	14,214	24,756	3,477	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,440,042	111,810	269,693	300,701	61,927	50.00
53.00	05300	ANESTHESIOLOGY	455	0	12,684	0	9,141	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,295,743	75,070	126,318	227,586	188,767	54.00
60.00	06000	LABORATORY	1,892,979	27,581	21,244	250,068	109,974	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	76,316	3,212	834	3,834	1,691	62.00
64.00	06400	INTRAVENOUS THERAPY	249,133	16,504	6,171	80,796	8,571	64.00
65.00	06500	RESPIRATORY THERAPY	892,700	54,299	419	21,386	17,746	65.00
66.00	06600	PHYSICAL THERAPY	551,202	36,487	1,714	0	26,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	104,870	6,007	283	0	4,418	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,491	0	0	0	4,351	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	128,541	0	0	0	5,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	114,743	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	47,171	1,963	0	15,356	304	90.01
91.00	09100	EMERGENCY	1,638,088	88,898	27,432	416,043	64,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,668,391	1,248,764	828,966	3,505,106	651,776	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,884	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	425,726	0	790	99,938	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	57,689	10,676	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	1,735,003	172,651	19,144	502,553	0	194.03
194.04	07954	340B PHARMACY	10,147	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,839,267	1,485,988	859,576	4,107,597	651,776	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,038,846					5.02
5.03	00590	OTHER ADMIN & GENERAL	0	3,609,785	3,609,785			5.03
7.00	00700	OPERATION OF PLANT	0	1,551,922	222,046	1,773,968		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,278	9,483	0	75,761	8.00
9.00	00900	HOUSEKEEPING	0	511,591	73,197	16,618	0	9.00
10.00	01000	DIETARY	0	244,843	35,032	63,402	0	10.00
11.00	01100	CAFETERIA	0	320,960	45,922	40,334	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	439,672	62,907	32,081	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	222,488	31,833	27,772	0	14.00
15.00	01500	PHARMACY	0	1,851,066	264,847	20,505	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	792,478	113,386	39,883	0	16.00
17.00	01700	SOCIAL SERVICE	0	317,292	45,398	4,309	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,703	2,691,645	385,115	233,667	18,039	30.00
31.00	03100	INTENSIVE CARE UNIT	0	42,447	6,073	46,897	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	97,587	2,281,760	326,470	211,810	10,724	50.00
53.00	05300	ANESTHESIOLOGY	14,404	36,684	5,249	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	297,446	3,210,930	459,415	142,211	16,284	54.00
60.00	06000	LABORATORY	173,301	2,475,147	354,139	52,248	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,664	88,551	12,670	6,084	0	62.00
64.00	06400	INTRAVENOUS THERAPY	13,506	374,681	53,609	31,265	0	64.00
65.00	06500	RESPIRATORY THERAPY	27,965	1,014,515	145,155	102,863	0	65.00
66.00	06600	PHYSICAL THERAPY	42,343	658,616	94,233	69,120	4,587	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,962	122,540	17,533	11,379	756	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,856	20,698	2,961	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,282	142,079	20,328	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	180,817	295,560	42,288	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	480	65,274	9,339	3,718	0	90.01
91.00	09100	EMERGENCY	101,757	2,336,791	334,343	168,406	25,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,027,073	25,786,293	3,172,971	1,324,572	75,761	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,884	985	13,041	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	526,454	75,324	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	11,773	80,138	11,466	109,285	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,429,351	347,587	327,070	0	194.03
194.04	07954	340B PHARMACY	0	10,147	1,452	0	0	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,038,846	28,839,267	3,609,785	1,773,968	75,761	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	601,406					9.00
10.00	01000	DIETARY	21,698	364,975				10.00
11.00	01100	CAFETERIA	13,803	0	421,019			11.00
13.00	01300	NURSING ADMINISTRATION	10,979	0	7,047	552,686		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,504	0	5,633	0	297,230	14.00
15.00	01500	PHARMACY	7,017	0	5,745	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,649	0	22,262	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,475	0	5,341	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	79,966	278,141	113,439	247,525	0	30.00
31.00	03100	INTENSIVE CARE UNIT	16,049	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,486	31,187	51,188	111,676	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,668	0	35,165	0	0	54.00
60.00	06000	LABORATORY	17,881	0	48,069	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,082	0	741	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	10,699	29,265	6,957	15,201	0	64.00
65.00	06500	RESPIRATORY THERAPY	35,202	0	1,773	3,828	0	65.00
66.00	06600	PHYSICAL THERAPY	23,654	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,894	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	297,230	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	1,272	0	1,459	0	0	90.01
91.00	09100	EMERGENCY	57,632	26,382	82,112	174,456	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	447,610	364,975	386,931	552,686	297,230	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,463	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	37,400	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	111,933	0	34,088	0	0	194.03
194.04	07954	340B PHARMACY	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)	601,406	364,975	421,019	552,686	297,230	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	2,149,180					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	981,658				16.00
17.00	01700	SOCIAL SERVICE	0	0	373,815			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	183,162	373,815	4,604,514	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	111,466	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	57,555	0	3,154,856	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	41,933	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	71,606	0	3,984,279	0	54.00
60.00	06000	LABORATORY	0	134,747	0	3,082,231	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	110,128	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	89,719	0	611,396	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,893	0	1,307,229	0	65.00
66.00	06600	PHYSICAL THERAPY	0	40,402	0	890,612	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,658	0	162,760	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	320,889	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	162,407	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,149,180	0	0	2,487,028	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	0	0	81,062	0	90.01
91.00	09100	EMERGENCY	0	393,916	0	3,599,409	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,149,180	981,658	373,815	24,712,199	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	25,373	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	601,778	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	238,289	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	0	3,250,029	0	194.03
194.04	07954	340B PHARMACY	0	0	0	11,599	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,149,180	981,658	373,815	28,839,267	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,604,514		30.00
31.00	03100	INTENSIVE CARE UNIT	111,466		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,154,856		50.00
53.00	05300	ANESTHESIOLOGY	41,933		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,984,279		54.00
60.00	06000	LABORATORY	3,082,231		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	110,128		62.00
64.00	06400	INTRAVENOUS THERAPY	611,396		64.00
65.00	06500	RESPIRATORY THERAPY	1,307,229		65.00
66.00	06600	PHYSICAL THERAPY	890,612		66.00
67.00	06700	OCCUPATIONAL THERAPY	162,760		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	320,889		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	162,407		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,487,028		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	04950	DIABETIC SERVICES	81,062		90.01
91.00	09100	EMERGENCY	3,599,409		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,712,199		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,373		190.00
194.00	07950	OCCUPATIONAL HEALTH	601,778		194.00
194.01	07951	FOUNDATION	0		194.01
194.02	07952	PHYSICIANS CLINICS	238,289		194.02
194.03	07953	HEALTH & WELLNESS CENTER	3,250,029		194.03
194.04	07954	340B PHARMACY	11,599		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	28,839,267		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,639	305	4,944	4,944	4.00
5.01	00570	ADMITTING	0	8,832	1,735	10,567	194	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	39,267	2,587	41,854	212	5.02
5.03	00590	OTHER ADMIN & GENERAL	0	365,345	176,963	542,308	592	5.03
7.00	00700	OPERATION OF PLANT	0	131,466	15,399	146,865	155	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,772	1,716	10,488	143	9.00
10.00	01000	DIETARY	0	33,469	2,265	35,734	40	10.00
11.00	01100	CAFETERIA	0	21,291	0	21,291	79	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,935	1,618	18,553	106	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,660	1,089	15,749	58	14.00
15.00	01500	PHARMACY	0	10,824	11,442	22,266	79	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,054	3,418	24,472	202	16.00
17.00	01700	SOCIAL SERVICE	0	2,275	0	2,275	91	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	123,348	140,160	263,508	682	30.00
31.00	03100	INTENSIVE CARE UNIT	0	24,756	3,477	28,233	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	111,810	269,693	381,503	362	50.00
53.00	05300	ANESTHESIOLOGY	0	0	12,684	12,684	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	75,070	126,318	201,388	274	54.00
60.00	06000	LABORATORY	0	27,581	21,244	48,825	301	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,212	834	4,046	5	62.00
64.00	06400	INTRAVENOUS THERAPY	0	16,504	6,171	22,675	97	64.00
65.00	06500	RESPIRATORY THERAPY	0	54,299	419	54,718	26	65.00
66.00	06600	PHYSICAL THERAPY	0	36,487	1,714	38,201	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,007	283	6,290	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	1,963	0	1,963	19	90.01
91.00	09100	EMERGENCY	0	88,898	27,432	116,330	501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,248,764	828,966	2,077,730	4,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,884	0	6,884	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	790	790	120	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	57,689	10,676	68,365	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	172,651	19,144	191,795	606	194.03
194.04	07954	340B PHARMACY	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	1,485,988	859,576	2,345,564	4,944	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	10,761					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	42,066				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	542,900			5.03
7.00	00700	OPERATION OF PLANT	0	0	33,394	180,414		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,426	0	1,426	8.00
9.00	00900	HOUSEKEEPING	0	0	11,008	1,690	0	9.00
10.00	01000	DIETARY	0	0	5,269	6,448	0	10.00
11.00	01100	CAFETERIA	0	0	6,906	4,102	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	9,461	3,263	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4,787	2,824	0	14.00
15.00	01500	PHARMACY	0	0	39,831	2,085	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	17,053	4,056	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	6,827	438	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	552	2,136	57,919	23,764	340	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	913	4,769	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,021	3,954	49,099	21,541	202	50.00
53.00	05300	ANESTHESIOLOGY	151	584	789	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,124	12,024	69,109	14,463	307	54.00
60.00	06000	LABORATORY	1,814	7,022	53,260	5,314	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	28	108	1,905	619	0	62.00
64.00	06400	INTRAVENOUS THERAPY	141	547	8,062	3,180	0	64.00
65.00	06500	RESPIRATORY THERAPY	293	1,133	21,830	10,461	0	65.00
66.00	06600	PHYSICAL THERAPY	443	1,716	14,172	7,030	86	66.00
67.00	06700	OCCUPATIONAL THERAPY	73	282	2,637	1,157	14	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	72	278	445	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87	336	3,057	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,892	7,327	6,360	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	5	19	1,405	378	0	90.01
91.00	09100	EMERGENCY	1,065	4,123	50,283	17,127	477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,761	41,589	477,207	134,709	1,426	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	148	1,326	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	11,328	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	477	1,724	11,114	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	52,275	33,265	0	194.03
194.04	07954	340B PHARMACY	0	0	218	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)	10,761	42,066	542,900	180,414	1,426	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	23,329					9.00
10.00	01000	DIETARY	842	48,333				10.00
11.00	01100	CAFETERIA	535	0	32,913			11.00
13.00	01300	NURSING ADMINISTRATION	426	0	551	32,360		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	369	0	440	0	24,227	14.00
15.00	01500	PHARMACY	272	0	449	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	529	0	1,740	0	0	16.00
17.00	01700	SOCIAL SERVICE	57	0	418	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,102	36,833	8,867	14,493	0	30.00
31.00	03100	INTENSIVE CARE UNIT	623	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,812	4,130	4,002	6,539	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,888	0	2,749	0	0	54.00
60.00	06000	LABORATORY	694	0	3,758	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	81	0	58	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	415	3,876	544	890	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,366	0	139	224	0	65.00
66.00	06600	PHYSICAL THERAPY	918	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	151	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	24,227	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	49	0	114	0	0	90.01
91.00	09100	EMERGENCY	2,236	3,494	6,419	10,214	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,365	48,333	30,248	32,360	24,227	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	173	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	1,451	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	4,340	0	2,665	0	0	194.03
194.04	07954	340B PHARMACY	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)	23,329	48,333	32,913	32,360	24,227	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	64,982					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,052				16.00
17.00	01700	SOCIAL SERVICE	0	0	10,106			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,966	10,106	431,268	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	34,538	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,817	0	477,982	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,208	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,505	0	308,831	0	54.00
60.00	06000	LABORATORY	0	6,596	0	127,584	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,850	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	4,392	0	44,819	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	191	0	90,381	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,978	0	64,544	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	326	0	10,930	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,022	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,480	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,982	0	0	80,561	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	0	0	3,952	0	90.01
91.00	09100	EMERGENCY	0	19,281	0	231,550	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,982	48,052	10,106	1,956,500	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8,531	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	12,238	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	83,131	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0	0	284,946	0	194.03
194.04	07954	340B PHARMACY	0	0	0	218	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	64,982	48,052	10,106	2,345,564	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	431,268		30.00
31.00	03100	INTENSIVE CARE UNIT	34,538		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	477,982		50.00
53.00	05300	ANESTHESIOLOGY	14,208		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,831		54.00
60.00	06000	LABORATORY	127,584		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	6,850		62.00
64.00	06400	INTRAVENOUS THERAPY	44,819		64.00
65.00	06500	RESPIRATORY THERAPY	90,381		65.00
66.00	06600	PHYSICAL THERAPY	64,544		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,930		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,022		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,480		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,561		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	04950	DIABETIC SERVICES	3,952		90.01
91.00	09100	EMERGENCY	231,550		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,956,500		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,531		190.00
194.00	07950	OCCUPATIONAL HEALTH	12,238		194.00
194.01	07951	FOUNDATION	0		194.01
194.02	07952	PHYSICIANS CLINICS	83,131		194.02
194.03	07953	HEALTH & WELLNESS CENTER	284,946		194.03
194.04	07954	340B PHARMACY	218		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,345,564		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,943					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		838,946				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312	298	11,727,962			4.00
5.01	00570	ADMITTING	594	1,693	458,742	62,489,442		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,641	2,525	502,452	0	63,205,734	5.02
5.03	00590	OTHER ADMIN & GENERAL	24,572	172,716	1,402,382	0	0	5.03
7.00	00700	OPERATION OF PLANT	8,842	15,029	368,395	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	590	1,675	339,414	0	0	9.00
10.00	01000	DIETARY	2,251	2,211	94,117	0	0	10.00
11.00	01100	CAFETERIA	1,432	0	187,082	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,139	1,579	251,917	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	986	1,063	136,517	0	0	14.00
15.00	01500	PHARMACY	728	11,167	188,194	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,416	3,336	478,542	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	216,048	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,296	136,796	1,627,168	3,206,567	3,206,567	30.00
31.00	03100	INTENSIVE CARE UNIT	1,665	3,394	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,520	263,219	858,558	5,937,376	5,937,376	50.00
53.00	05300	ANESTHESIOLOGY	0	12,380	0	876,374	876,374	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,049	123,286	649,801	18,097,375	18,097,375	54.00
60.00	06000	LABORATORY	1,855	20,734	713,991	10,543,993	10,543,993	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	216	814	10,947	162,100	162,100	62.00
64.00	06400	INTRAVENOUS THERAPY	1,110	6,023	230,687	821,759	821,759	64.00
65.00	06500	RESPIRATORY THERAPY	3,652	409	61,060	1,701,470	1,701,470	65.00
66.00	06600	PHYSICAL THERAPY	2,454	1,673	0	2,576,242	2,576,242	66.00
67.00	06700	OCCUPATIONAL THERAPY	404	276	0	423,587	423,587	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	417,119	417,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	503,924	503,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,001,262	11,001,262	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	132	0	43,843	29,186	29,186	90.01
91.00	09100	EMERGENCY	5,979	26,774	1,187,881	6,191,108	6,191,108	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,988	809,070	10,007,738	62,489,442	62,489,442	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	463	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	771	285,342	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	3,880	10,420	0	0	716,292	194.02
194.03	07953	HEALTH & WELLNESS CENTER	11,612	18,685	1,434,882	0	0	194.03
194.04	07954	340B PHARMACY	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)	1,485,988	859,576	4,107,597	651,776	1,038,846	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.868355	1.024590	0.350240	0.010430	0.016436	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,944	10,761	42,066	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000422	0.000172	0.000666	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: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL	-3,609,785	25,229,482				5.03
7.00	00700	OPERATION OF PLANT	0	1,551,922	62,982			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,278	0	110,856		8.00
9.00	00900	HOUSEKEEPING	0	511,591	590	0	62,392	9.00
10.00	01000	DIETARY	0	244,843	2,251	0	2,251	10.00
11.00	01100	CAFETERIA	0	320,960	1,432	0	1,432	11.00
13.00	01300	NURSING ADMINISTRATION	0	439,672	1,139	0	1,139	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	222,488	986	0	986	14.00
15.00	01500	PHARMACY	0	1,851,066	728	0	728	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	792,478	1,416	0	1,416	16.00
17.00	01700	SOCIAL SERVICE	0	317,292	153	0	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,691,645	8,296	26,395	8,296	30.00
31.00	03100	INTENSIVE CARE UNIT	0	42,447	1,665	0	1,665	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,281,760	7,520	15,692	7,520	50.00
53.00	05300	ANESTHESIOLOGY	0	36,684	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,210,930	5,049	23,827	5,049	54.00
60.00	06000	LABORATORY	0	2,475,147	1,855	0	1,855	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	88,551	216	0	216	62.00
64.00	06400	INTRAVENOUS THERAPY	0	374,681	1,110	0	1,110	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,014,515	3,652	0	3,652	65.00
66.00	06600	PHYSICAL THERAPY	0	658,616	2,454	6,712	2,454	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	122,540	404	1,106	404	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,698	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	142,079	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	295,560	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	65,274	132	0	132	90.01
91.00	09100	EMERGENCY	0	2,336,791	5,979	37,124	5,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,609,785	22,176,508	47,027	110,856	46,437	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,884	463	0	463	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	526,454	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	80,138	3,880	0	3,880	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	2,429,351	11,612	0	11,612	194.03
194.04	07954	340B PHARMACY	0	10,147	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)		3,609,785	1,773,968	75,761	601,406	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.143078	28.166270	0.683418	9.639152	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		542,900	180,414	1,426	23,329	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.021518	2.864533	0.012864	0.373910	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: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	7,595					10.00
11.00	01100	CAFETERIA	0	18,761				11.00
13.00	01300	NURSING ADMINISTRATION	0	314	234,772			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	251	0	100		14.00
15.00	01500	PHARMACY	0	256	0	0	1,390,135	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	992	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	238	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,788	5,055	105,145	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	649	2,281	47,438	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,567	0	0	0	54.00
60.00	06000	LABORATORY	0	2,142	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	33	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	609	310	6,457	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	79	1,626	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	100	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	1,390,135	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	65	0	0	0	90.01
91.00	09100	EMERGENCY	549	3,659	74,106	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,595	17,242	234,772	100	1,390,135	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	0	0	194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	1,519	0	0	0	194.03
194.04	07954	340B PHARMACY	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)	364,975	421,019	552,686	297,230	2,149,180	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.054641	22.441181	2.354139	2,972.300000	1.546023	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,333	32,913	32,360	24,227	64,982	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.363792	1.754331	0.137836	242.270000	0.046745	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: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 8/16/2018 9:23 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
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	86,985			16.00
17.00	01700	SOCIAL SERVICE	0	1,241		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	16,230	1,241		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	5,100	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,345	0		54.00
60.00	06000	LABORATORY	11,940	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	7,950	0		64.00
65.00	06500	RESPIRATORY THERAPY	345	0		65.00
66.00	06600	PHYSICAL THERAPY	3,580	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	590	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	DIABETIC SERVICES	0	0		90.01
91.00	09100	EMERGENCY	34,905	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,985	1,241		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	0		194.02
194.03	07953	HEALTH & WELLNESS CENTER	0	0		194.03
194.04	07954	340B PHARMACY	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)	981,658	373,815		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.285371	301.220790		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,052	10,106		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.552417	8.143433		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

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-2 | Date/Time Prepared: 8/16/2018 9:23 am

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,604,514		4,604,514	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	111,466		111,466	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,154,856		3,154,856	0	0	50.00
53.00	05300	ANESTHESIOLOGY	41,933		41,933	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,984,279		3,984,279	0	0	54.00
60.00	06000	LABORATORY	3,082,231		3,082,231	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	110,128		110,128	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	611,396		611,396	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,307,229	0	1,307,229	0	0	65.00
66.00	06600	PHYSICAL THERAPY	890,612	0	890,612	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,760	0	162,760	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	320,889		320,889	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	162,407		162,407	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,487,028		2,487,028	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	04950	DIABETIC SERVICES	81,062		81,062	0	0	90.01
91.00	09100	EMERGENCY	3,599,409		3,599,409	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,180,299		1,180,299		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,892,498	0	25,892,498	0	0	200.00
201.00		Less Observation Beds	1,180,299		1,180,299		0	201.00
202.00		Total (see instructions)	24,712,199	0	24,712,199	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,680,000		1,680,000			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	552,674	5,384,702	5,937,376	0.531355	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	79,265	797,109	876,374	0.047848	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	463,874	17,633,501	18,097,375	0.220158	0.000000	54.00
60.00	06000	LABORATORY	574,366	9,969,627	10,543,993	0.292321	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	26,015	136,085	162,100	0.679383	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	821,759	821,759	0.744009	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	340,473	1,360,997	1,701,470	0.768294	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	116,775	2,459,467	2,576,242	0.345702	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	423,587	423,587	0.384242	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	274,212	142,907	417,119	0.769298	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	236,033	267,891	503,924	0.322285	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,250,661	9,750,601	11,001,262	0.226068	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04950	DIABETIC SERVICES	0	29,186	29,186	2.777428	0.000000	90.01
91.00	09100	EMERGENCY	899	6,190,209	6,191,108	0.581384	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,526,567	1,526,567	0.773172	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,595,247	56,894,195	62,489,442			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,595,247	56,894,195	62,489,442			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	DIABETIC SERVICES	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 8/16/2018 9:23 am

Title XIX | Hospital

		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	4,604,514		4,604,514	0	4,604,514	30.00
31.00	03100	INTENSIVE CARE UNIT	111,466		111,466	0	111,466	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,154,856		3,154,856	0	3,154,856	50.00
53.00	05300	ANESTHESIOLOGY	41,933		41,933	0	41,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,984,279		3,984,279	0	3,984,279	54.00
60.00	06000	LABORATORY	3,082,231		3,082,231	0	3,082,231	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	110,128		110,128	0	110,128	62.00
64.00	06400	INTRAVENOUS THERAPY	611,396		611,396	0	611,396	64.00
65.00	06500	RESPIRATORY THERAPY	1,307,229	0	1,307,229	0	1,307,229	65.00
66.00	06600	PHYSICAL THERAPY	890,612	0	890,612	0	890,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,760	0	162,760	0	162,760	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	320,889		320,889	0	320,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	162,407		162,407	0	162,407	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,487,028		2,487,028	0	2,487,028	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	04950	DIABETIC SERVICES	81,062		81,062	0	81,062	90.01
91.00	09100	EMERGENCY	3,599,409		3,599,409	0	3,599,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,180,299		1,180,299		1,180,299	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,892,498	0	25,892,498	0	25,892,498	200.00
201.00		Less Observation Beds	1,180,299		1,180,299		1,180,299	201.00
202.00		Total (see instructions)	24,712,199	0	24,712,199	0	24,712,199	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 8/16/2018 9:23 am

Title XIX | Hospital

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,680,000		1,680,000			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	552,674	5,384,702	5,937,376	0.531355	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	79,265	797,109	876,374	0.047848	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	463,874	17,633,501	18,097,375	0.220158	0.000000	54.00
60.00	06000	LABORATORY	574,366	9,969,627	10,543,993	0.292321	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	26,015	136,085	162,100	0.679383	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	821,759	821,759	0.744009	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	340,473	1,360,997	1,701,470	0.768294	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	116,775	2,459,467	2,576,242	0.345702	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	423,587	423,587	0.384242	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	274,212	142,907	417,119	0.769298	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	236,033	267,891	503,924	0.322285	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,250,661	9,750,601	11,001,262	0.226068	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04950	DIABETIC SERVICES	0	29,186	29,186	2.777428	0.000000	90.01
91.00	09100	EMERGENCY	899	6,190,209	6,191,108	0.581384	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,526,567	1,526,567	0.773172	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,595,247	56,894,195	62,489,442			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,595,247	56,894,195	62,489,442			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 8/16/2018 9:23 am

Title XIX | Hospital

		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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	DIABETIC SERVICES	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part II Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	477,982	5,937,376	0.080504	284,090	22,870	50.00
53.00	05300	ANESTHESIOLOGY	14,208	876,374	0.016212	43,642	708	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,831	18,097,375	0.017065	308,711	5,268	54.00
60.00	06000	LABORATORY	127,584	10,543,993	0.012100	382,611	4,630	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	6,850	162,100	0.042258	19,462	822	62.00
64.00	06400	INTRAVENOUS THERAPY	44,819	821,759	0.054540	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	90,381	1,701,470	0.053119	213,963	11,366	65.00
66.00	06600	PHYSICAL THERAPY	64,544	2,576,242	0.025054	69,238	1,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,930	423,587	0.025803	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,022	417,119	0.059988	205,539	12,330	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,480	503,924	0.006906	183,878	1,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,561	11,001,262	0.007323	711,822	5,213	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC SERVICES	3,952	29,186	0.135407	0	0	90.01
91.00	09100	EMERGENCY	231,550	6,191,108	0.037400	787	29	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	110,549	1,526,567	0.072417	0	0	92.00
200.00		Total (lines 50 through 199)	1,601,243	60,809,442		2,423,743	66,241	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
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: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		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	5,937,376	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	876,374	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,097,375	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,543,993	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	162,100	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	821,759	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,701,470	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,576,242	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	423,587	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	417,119	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	503,924	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,001,262	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	DIABETIC SERVICES	0	0	0	29,186	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	6,191,108	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,526,567	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	60,809,442		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		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	284,090	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	43,642	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	308,711	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	382,611	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	19,462	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	213,963	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	69,238	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	205,539	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	183,878	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	711,822	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	787	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,423,743	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.531355	0	1,909,775	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.047848	0	328,521	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.220158	0	5,205,370	0	0	54.00
60.00	06000	LABORATORY	0.292321	0	3,632,526	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.679383	0	48,173	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.744009	0	347,906	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.768294	0	523,123	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.345702	0	651,156	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384242	0	70,276	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769298	0	71,059	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.322285	0	43,480	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226068	0	4,699,017	135	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	2.777428	0	9,833	0	0	90.01
91.00	09100	EMERGENCY	0.581384	0	1,669,599	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.773172	0	644,339	0	0	92.00
200.00		Subtotal (see instructions)		0	19,854,153	135	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	19,854,153	135	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,014,768	0		50.00
53.00	05300	ANESTHESIOLOGY	15,719	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,146,004	0		54.00
60.00	06000	LABORATORY	1,061,864	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	32,728	0		62.00
64.00	06400	INTRAVENOUS THERAPY	258,845	0		64.00
65.00	06500	RESPIRATORY THERAPY	401,912	0		65.00
66.00	06600	PHYSICAL THERAPY	225,106	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	27,003	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,666	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,013	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,062,297	31		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	DIABETIC SERVICES	27,310	0		90.01
91.00	09100	EMERGENCY	970,678	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	498,185	0		92.00
200.00		Subtotal (see instructions)	6,811,098	31		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,811,098	31		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Swing Beds - SNF

		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	0.531355	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.047848	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.220158	0	0	0	0	54.00
60.00	06000	LABORATORY	0.292321	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.679383	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.744009	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.768294	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.345702	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384242	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769298	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.322285	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226068	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC SERVICES	2.777428	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.581384	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.773172	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Swing Beds - SNF

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	DIABETIC SERVICES	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,766	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,692	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)	1,241	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	50	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)	17	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	726	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)	50	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)	17	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,604,514	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)	1,088	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)	176,432	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,428,082	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)	4,428,082	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)	2,617.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,899,993	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)	1,899,993	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	111,466	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)	913,155	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,813,148	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	130,854	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	44,490	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	175,344	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)	451	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,617.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,180,299	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	431,268	4,604,514	0.093662	1,180,299	110,549	90.00
91.00	Nursing School cost	0	4,604,514	0.000000	1,180,299	0	91.00
92.00	Allied health cost	0	4,604,514	0.000000	1,180,299	0	92.00
93.00	All other Medical Education	0	4,604,514	0.000000	1,180,299	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-3 | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		943,800		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.531355	284,090	150,953	50.00
53.00	05300	ANESTHESIOLOGY	0.047848	43,642	2,088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.220158	308,711	67,965	54.00
60.00	06000	LABORATORY	0.292321	382,611	111,845	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.679383	19,462	13,222	62.00
64.00	06400	INTRAVENOUS THERAPY	0.744009	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.768294	213,963	164,386	65.00
66.00	06600	PHYSICAL THERAPY	0.345702	69,238	23,936	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384242	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769298	205,539	158,121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.322285	183,878	59,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226068	711,822	160,920	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	04950	DIABETIC SERVICES	2.777428	0	0	90.01
91.00	09100	EMERGENCY	0.581384	787	458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.773172	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,423,743	913,155	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)		2,423,743		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-3 | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Swing Beds - SNF

		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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.531355	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.047848	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.220158	5,859	1,290	54.00
60.00	06000	LABORATORY	0.292321	7,062	2,064	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.679383	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.744009	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.768294	13,520	10,387	65.00
66.00	06600	PHYSICAL THERAPY	0.345702	24,438	8,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384242	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769298	1,512	1,163	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.322285	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226068	33,458	7,564	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	04950	DIABETIC SERVICES	2.777428	0	0	90.01
91.00	09100	EMERGENCY	0.581384	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.773172	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		85,849	30,916	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)		85,849		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1312	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part B Date/Time Prepared: 8/16/2018 9:23 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,811,129	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	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)	6,811,129	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,879,240	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	37,629	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,296,577	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)	3,545,034	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)	3,545,034	30.00
31.00	Primary payer payments	20	31.00
32.00	Subtotal (line 30 minus line 31)	3,545,014	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)	833,580	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	541,827	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	623,554	36.00
37.00	Subtotal (see instructions)	4,086,841	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)	4,086,841	40.00
40.01	Sequestration adjustment (see instructions)	81,737	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,013,491	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-8,387	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: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,702,027		4,013,491	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)		2,702,027		4,013,491	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		102,477		8,387	6.02
7.00	Total Medicare program liability (see instructions)		2,599,550		4,005,104	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: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Swing Beds - SNF

		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		202,138		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)		202,138		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		2,018		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		204,156		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: 14-1312	Period: From 05/01/2017 To 04/30/2018	Worksheet E-1 Part II Date/Time Prepared: 8/16/2018 9:23 am
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
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 - SWING BEDS

Provider CCN: 14-1312 | Component CCN: 14-Z312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-2 | Date/Time Prepared: 8/16/2018 9:23 am

Title XVIII | Swing Beds - SNF

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	177,097	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	31,225	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	67	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	208,322	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	208,322	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	208,322	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	208,322	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	208,322	0	19.00
19.01	Sequestration adjustment (see instructions)	4,166	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	202,138	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	2,018	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1312	Period: From 05/01/2017 To 04/30/2018	Worksheet E-3 Part V Date/Time Prepared: 8/16/2018 9:23 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,813,148	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,813,148	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,841,279	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,841,279	19.00
20.00	Deductibles (exclude professional component)	232,936	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,608,343	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,608,343	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	68,090	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	44,259	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	41,848	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,652,602	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,652,602	30.00
30.01	Sequestration adjustment (see instructions)	53,052	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,702,027	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-102,477	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G | Date/Time Prepared: 8/16/2018 9:23 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	11,828,666	0	0	0	1.00
2.00	Temporary investments	10,297,976	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,117,089	0	0	0	4.00
5.00	Other receivable	357,988	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,361,640	0	0	0	6.00
7.00	Inventory	249,591	0	0	0	7.00
8.00	Prepaid expenses	695,351	0	0	0	8.00
9.00	Other current assets	7,998	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)	28,193,019	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,389,097	0	0	0	12.00
13.00	Land improvements	1,765,116	0	0	0	13.00
14.00	Accumulated depreciation	-1,084,882	0	0	0	14.00
15.00	Buildings	20,765,822	0	0	0	15.00
16.00	Accumulated depreciation	-9,556,387	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	3,019,344	0	0	0	19.00
20.00	Accumulated depreciation	-1,306,239	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,596,399	0	0	0	23.00
24.00	Accumulated depreciation	-6,585,445	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	3,868,112	0	0	0	27.00
28.00	Accumulated depreciation	-3,624,131	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)	20,246,806	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	66,915	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	66,915	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,506,740	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	740,872	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,794,153	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	525,036	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	315,804	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,375,865	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	6,989,626	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	61,465	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,051,091	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,426,956	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	38,079,784				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)	38,079,784	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,506,740	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G-1 | Date/Time Prepared: 8/16/2018 9:23 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		34,204,703		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,875,081				2.00
3.00	Total (sum of line 1 and line 2)		38,079,784		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)		38,079,784		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)		38,079,784		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: 14-1312 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 8/16/2018 9:23 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,593,945		1,593,945	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	86,055		86,055	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,680,000		1,680,000	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,680,000		1,680,000	17.00
18.00	Ancillary services	3,914,348	49,148,233	53,062,581	18.00
19.00	Outpatient services	899	7,745,962	7,746,861	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL CHARGES	0	2,897,126	2,897,126	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,595,247	59,791,321	65,386,568	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,691,109		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)		31,691,109		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1312	Period: From 05/01/2017 To 04/30/2018	Worksheet G-3 Date/Time Prepared: 8/16/2018 9:23 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	65,386,568	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,254,154	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,132,414	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,691,109	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,441,305	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	32,832	6.00
7.00	Income from investments	170,430	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	115,988	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	7,781	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	127,658	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT INCOME	15,276	24.00
24.01	340B INCOME	19,942	24.01
24.02	FITNESS CENTER	67,618	24.02
24.03	MISC INCOME	167,063	24.03
24.04	UNREALIZED GAIN ON INVESTMENTS	685,933	24.04
24.05	GAIN ON DISPOSAL OF ASSETS	23,255	24.05
25.00	Total other income (sum of lines 6-24)	1,433,776	25.00
26.00	Total (line 5 plus line 25)	3,875,081	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,875,081	29.00