This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1350	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/16/2018 11:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/16/2018 Time: 11:15 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 ST. FRANCIS HOSPITAL (14-1350) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-176,482	449,494	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	28,480	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-148,002	449,494	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/16/2018 10:51 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1215 FRANCISCAN DRIVE	PO Box:			1.00
2.00	City: LITCHFIELD	State: IL	Zip Code: 62056	County: MONTGOMERY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. FRANCIS HOSPITAL	141350	99914	1	12/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. FRANCIS HOSPITAL	14Z350	99914		05/31/2007	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 10:51 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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/16/2018 10:51 am

		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: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 10:51 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

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		1.00	2.00	3.00	
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

		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

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A 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

		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:	47,774	33,106	357,966	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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 10:51 am

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	148005	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONA GOVERNMENT SERVICES	Contractor's Number: 00131	141.00
142.00	Street: 4736 LAVERNA ROAD	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62794	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2017	06/30/2018	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1350	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 10:51 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/16/2018 10:51 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	09/27/2018	Y	09/27/2018	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: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/16/2018 10:51 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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	211 N BROADWAY STE 600, ST LOUIS, MO	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1350	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/16/2018 10:51 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: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/16/2018 10:51 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	25	9,125	90,192.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	90,192.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	90,192.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/16/2018 10:51 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)	2,346	485	3,722			1.00
2.00	HMO and other (see instructions)	362	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	531	0	569			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	34			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,877	485	4,325			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		232	404			13.00
14.00	Total (see instructions)	2,877	717	4,729	0.00	212.92	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	212.92	27.00
28.00	Observation Bed Days		54	665			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			17			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: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/16/2018 10:51 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	659	180	1,238	1.00
2.00	HMO and other (see instructions)			92	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	659	180	1,238	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: 14-1350	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/16/2018 10:51 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)	0.282964	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,426,702	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?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	27,203,776	6.00
7.00	Medicaid cost (line 1 times line 6)	7,697,689	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,158,081	495,681	1,653,762	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	327,695	495,681	823,376	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)	327,695	495,681	823,376	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,826,813	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,183,231	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,820,355	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,006,458	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	921,915	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,745,291	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,745,291	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/16/2018 10:51 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		478,529	478,529	1,410,023	1,888,552	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,630,544	2,630,544	-1,416,341	1,214,203	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	96,033	1,659,273	1,755,306	2,623	1,757,929	4.00
5.01	00570	ADMITTING	350,278	27,644	377,922	13,247	391,169	5.01
5.02	00540	PATIENT ACCOUNTING	0	541,085	541,085	0	541,085	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	1,502,143	6,297,000	7,799,143	-162,568	7,636,575	5.03
6.00	00600	MAINTENANCE & REPAIRS	289,530	28,046	317,576	0	317,576	6.00
7.00	00700	OPERATION OF PLANT	68,177	1,132,701	1,200,878	0	1,200,878	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	127,580	127,580	8.00
9.00	00900	HOUSEKEEPING	271,562	233,269	504,831	0	504,831	9.00
10.00	01000	DIETARY	335,608	242,021	577,629	-471,045	106,584	10.00
11.00	01100	CAFETERIA	0	0	0	470,910	470,910	11.00
13.00	01300	NURSING ADMINISTRATION	166,490	9,792	176,282	0	176,282	13.00
15.00	01500	PHARMACY	499,024	1,984,098	2,483,122	-1,730,328	752,794	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	264,941	277,717	542,658	72,386	615,044	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,639,713	481,606	3,121,319	-919,717	2,201,602	30.00
43.00	04300	NURSERY	0	0	0	110,074	110,074	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,094,510	1,563,419	2,657,929	-484,352	2,173,577	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	562,242	562,242	52.00
53.00	05300	ANESTHESIOLOGY	0	547,821	547,821	-21,721	526,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	917,053	330,907	1,247,960	-29,312	1,218,648	54.00
57.00	05700	CT SCAN	101,982	206,213	308,195	7,056	315,251	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	93,636	141,866	235,502	5,475	240,977	58.00
60.00	06000	LABORATORY	585,286	1,176,030	1,761,316	171,018	1,932,334	60.00
65.00	06500	RESPIRATORY THERAPY	348,477	217,537	566,014	15,367	581,381	65.00
66.00	06600	PHYSICAL THERAPY	133,405	779,941	913,346	-576	912,770	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	126,875	126,875	130,345	257,220	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	414,842	414,842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,745,236	1,745,236	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	189,142	24,471	213,613	2,569	216,182	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	234,710	877,285	1,111,995	-2,131	1,109,864	90.00
91.00	09100	EMERGENCY	1,240,080	1,508,611	2,748,691	-58,781	2,689,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,421,780	23,524,301	34,946,081	-35,879	34,910,202	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,571	39,571	0	39,571	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126,713	382,291	509,004	35,879	544,883	192.00
194.00	07950	OTHER NONALLOWABLE	63,943	55,700	119,643	0	119,643	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	11,612,436	24,001,863	35,614,299	0	35,614,299	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/16/2018 10:51 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	0	1,888,552		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-834,621	379,582		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,215,226	4,973,155		4.00
5.01	00570	ADMITTING	0	391,169		5.01
5.02	00540	PATIENT ACCOUNTING	20,036	561,121		5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-1,126,024	6,510,551		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	317,576		6.00
7.00	00700	OPERATION OF PLANT	-6,966	1,193,912		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	127,580		8.00
9.00	00900	HOUSEKEEPING	-412	504,419		9.00
10.00	01000	DIETARY	0	106,584		10.00
11.00	01100	CAFETERIA	0	470,910		11.00
13.00	01300	NURSING ADMINISTRATION	-491	175,791		13.00
15.00	01500	PHARMACY	0	752,794		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-469	614,575		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-179,069	2,022,533		30.00
43.00	04300	NURSERY	0	110,074		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,173,577		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	562,242		52.00
53.00	05300	ANESTHESIOLOGY	-439,273	86,827		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,329	1,217,319		54.00
57.00	05700	CT SCAN	0	315,251		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	240,977		58.00
60.00	06000	LABORATORY	-7,875	1,924,459		60.00
65.00	06500	RESPIRATORY THERAPY	-111,645	469,736		65.00
66.00	06600	PHYSICAL THERAPY	0	912,770		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	257,220		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	414,842		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,745,236		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	216,182		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-757,430	352,434		90.00
91.00	09100	EMERGENCY	-203,987	2,485,923		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-434,329	34,475,873		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,571		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	544,883		192.00
194.00	07950	OTHER NONALLOWABLE	0	119,643		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-434,329	35,179,970		200.00

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/16/2018 10:51 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - L&D AND NURSERY SAL & OTHER EXP				
1.00	NURSERY	43.00	104,966	12,045	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	538,811	61,829	2.00
	0		643,777	73,874	
	B - DRUG COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,745,236	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	1,745,236	
	C - CAFETERIA SALARIES & OTHER COSTS				
1.00	CAFETERIA	11.00	273,603	197,307	1.00
	0		273,603	197,307	
	D - LAUNDRY COSTS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	127,580	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	127,580	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	208,778	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	336,542	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	545,320	
	F - LAB ADMINISTRATION COSTS				
1.00	LABORATORY	60.00	143,323	27,975	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		143,323	27,975	
	G - MOB DEPRECIATION COSTS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	36,812	1.00
	0		0	36,812	
	H - SHARED SERVICES COSTS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,623	0	1.00
2.00	ADMITTING	5.01	13,247	0	2.00
3.00	PHARMACY	15.00	287	0	3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	74,581	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	15,947	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	642	0	6.00
7.00	CT SCAN	57.00	605	0	7.00
8.00	RESPIRATORY THERAPY	65.00	15,367	0	8.00
9.00	CARDIAC REHABILITATION	76.97	2,569	0	9.00
	0		125,868	0	
	I - BUILDING INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	30,494	1.00
	0		0	30,494	
	J - RADIOLOGY MANAGERS COST				
1.00	CT SCAN	57.00	10,744	0	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	7,520	0	2.00
	0		18,264	0	

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/16/2018 10:51 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	O - SEGREGATE DIRECT COSTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	78,300		1.00
	0		0	78,300		
	P - DEPRECIATION EXPENSE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,379,529		1.00
	0		0	1,379,529		
500.00	Grand Total: Increases		1,204,835	4,242,427		500.00

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/16/2018 10:51 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - L&D AND NURSERY SAL & OTHER EXP						
1.00	ADULTS & PEDIATRICS	30.00	643,777	73,874	0		1.00
2.00		0.00	0	0	0		2.00
	0		643,777	73,874			
	B - DRUG COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.03	0	6,206	0		1.00
2.00	DIETARY	10.00	0	135	0		2.00
3.00	PHARMACY	15.00	0	1,729,085	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	436	0		4.00
5.00	OPERATING ROOM	50.00	0	1,869	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	4,386	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	494	0		7.00
8.00	CT SCAN	57.00	0	430	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	226	0		9.00
10.00	LABORATORY	60.00	0	280	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	6	0		11.00
12.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	133	0		12.00
13.00	EMERGENCY	91.00	0	1,550	0		13.00
	0		0	1,745,236			
	C - CAFETERIA SALARIES & OTHER COSTS						
1.00	DIETARY	10.00	273,603	197,307	0		1.00
	0		273,603	197,307			
	D - LAUNDRY COSTS						
1.00	PHARMACY	15.00	0	1,530	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,195	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	51,445	0		3.00
4.00	NURSERY	43.00	0	2,487	0		4.00
5.00	OPERATING ROOM	50.00	0	17,641	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	12,769	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,196	0		7.00
8.00	CT SCAN	57.00	0	3,863	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,819	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	570	0		10.00
11.00	CLINIC	90.00	0	2,131	0		11.00
12.00	EMERGENCY	91.00	0	19,001	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	933	0		13.00
	0		0	127,580			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	5,137	0		1.00
2.00	NURSERY	43.00	0	4,450	0		2.00
3.00	OPERATING ROOM	50.00	0	464,842	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	22,844	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	17,335	0		5.00
6.00	EMERGENCY	91.00	0	30,712	0		6.00
	0		0	545,320			
	F - LAB ADMINISTRATION COSTS						
1.00	ADULTS & PEDIATRICS	30.00	137,213	23,782	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,656	129	0		2.00
3.00	EMERGENCY	91.00	3,454	4,064	0		3.00
	0		143,323	27,975			
	G - MOB DEPRECIATION COSTS						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	36,812	9		1.00
	0		0	36,812			
	H - SHARED SERVICES COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.03	125,868	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		125,868	0			
	I - BUILDING INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.03	0	30,494	12		1.00
	0		0	30,494			
	J - RADIOLOGY MANAGERS COST						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	18,264	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		18,264	0			

RECLASSIFICATIONS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/16/2018 10:51 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	O - SEGREGATE DIRECT COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	78,300	0		1.00
	0		0	78,300			
	P - DEPRECIATION EXPENSE RECLASS						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,379,529	9		1.00
	0		0	1,379,529			
500.00	Grand Total: Decreases		1,204,835	4,242,427			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/16/2018 10:51 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	99,383	310,645	0	310,645	0	1.00
2.00	Land Improvements	1,922,999	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,429,844	496,974	0	496,974	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	26,058,098	932,609	0	932,609	0	5.00
6.00	Movable Equipment	16,613,998	2,022,911	0	2,022,911	0	6.00
7.00	HIT designated Assets	5,136,661	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,260,983	3,763,139	0	3,763,139	0	8.00
9.00	Reconciling Items	55,881	0	0	0	55,881	9.00
10.00	Total (line 8 minus line 9)	61,205,102	3,763,139	0	3,763,139	-55,881	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	410,028	0	1.00
2.00	Land Improvements	1,922,999	0	2.00
3.00	Buildings and Fixtures	11,926,818	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	26,990,707	0	5.00
6.00	Movable Equipment	18,636,909	0	6.00
7.00	HIT designated Assets	5,136,661	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,024,122	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	65,024,122	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/16/2018 10:51 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	448,035	0	0	30,494	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,630,544	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,078,579	0	0	30,494	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	478,529		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,630,544		2.00
3.00	Total (sum of lines 1-2)	0	3,109,073		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/16/2018 10:51 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	41,250,552	0	41,250,552	0.634388	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,773,570	0	23,773,570	0.365612	0	2.00
3.00	Total (sum of lines 1-2)	65,024,122	0	65,024,122	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,827,564	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	379,582	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,207,146	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	0	60,988	0	0	1,888,552	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	379,582	2.00
3.00	Total (sum of lines 1-2)	0	60,988	0	0	2,268,134	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/16/2018 10:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,914	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,691,372			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,070,771			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing 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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/16/2018 10:51 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	
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	-834,621	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MARKETING SALARY	A	-88,251	ADMINISTRATIVE & GENERAL	5.03	0	33.00
33.01	MARKETING BENEFITS	B	-12,066	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MARKETING OTHER	B	-201,382	ADMINISTRATIVE & GENERAL	5.03	0	33.02
33.03	MISC INCOME	B	-313,551	ADMINISTRATIVE & GENERAL	5.03	0	33.03
33.04	BANK CHARGES	A	20,036	PATIENT ACCOUNTING	5.02	0	33.04
33.05	LAB MISC INCOME	B	-7,875	LABORATORY	60.00	0	33.05
33.06	RADIOLOGY MISC REVENUE	B	-1,329	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	HIS MISC INCOME	B	-469	MEDICAL RECORDS & LIBRARY	16.00	0	33.07
33.08	ALCOHOL BEVERAGE COST	A	-32	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	ALCOHOL BEVERAGE COST	A	-146	ADMINISTRATIVE & GENERAL	5.03	0	33.09
33.10	ALCOHOL BEVERAGE COST	A	-194	NURSING ADMINISTRATION	13.00	0	33.10
33.11	ADVERTISING COST	A	0	ADMINISTRATIVE & GENERAL	5.03	0	33.11
33.12	ADVERTISING COST	A	-10,765	ADMINISTRATIVE & GENERAL	5.03	0	33.12
33.13	DEFINED PENSION ADJUSTMENT	A	3,934,748	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	FUND DEVELOPMENT - SALARY	A	-98,968	ADMINISTRATIVE & GENERAL	5.03	0	33.14
33.15	FUND DEVELOPMENT - OTHER	B	53,311	ADMINISTRATIVE & GENERAL	5.03	0	33.15
33.16	SELF-INS TO HOSP/EMP CLIMS	A	-669,585	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	PHYSICIAN RECRUITMENT	A	-136,929	ADMINISTRATIVE & GENERAL	5.03	0	33.17
33.18	MEDICAID TAX ASSESSMENT	A	-1,344,174	ADMINISTRATIVE & GENERAL	5.03	0	33.18
33.19	LOBBYING EXPENSES	A	-15,812	ADMINISTRATIVE & GENERAL	5.03	0	33.19
33.20	MEALS TO NON-PROVIDERS	A	-42,339	ADMINISTRATIVE & GENERAL	5.03	0	33.20
33.21	CHARITABLE CONTRIBUTIONS	A	-6,560	ADMINISTRATIVE & GENERAL	5.03	0	33.21
33.22	NON-PATIENT TRAVEL	A	-15,571	ADMINISTRATIVE & GENERAL	5.03	0	33.22
33.23	NON-PATIENT TRAVEL	A	-52	OPERATION OF PLANT	7.00	0	33.23
33.24	NON-PATIENT TRAVEL	A	-412	HOUSEKEEPING	9.00	0	33.24
33.25	NON-PATIENT TRAVEL	A	-297	NURSING ADMINISTRATION	13.00	0	33.25
33.26	FUND DEVELOPMENT - BENEFITS	A	-13,529	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-434,329				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/16/2018 10:51 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF-INS PREMIUMS	2,747,609	2,771,951	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY SVCS	18,388	18,388	2.00
3.00	5.03	ADMINISTRATIVE & GENERAL	CONTRACT SERVICES - HSHS	3,828,285	2,733,172	3.00
3.01	5.03	ADMINISTRATIVE & GENERAL	RELATED PARTY SVCS	721,377	721,377	3.01
3.02	5.01	ADMITTING	RELATED PARTY SVCS	16,633	16,633	3.02
3.03	5.02	PATIENT ACCOUNTING	RELATED PARTY SVCS	40,997	40,997	3.03
3.04	9.00	HOUSEKEEPING	RELATED PARTY SVCS	95	95	3.04
3.05	10.00	DIETARY	RELATED PARTY SVCS	419	419	3.05
3.06	13.00	NURSING ADMINISTRATION	RELATED PARTY SVCS	459	459	3.06
3.07	15.00	PHARMACY	RELATED PARTY SVCS	6,272	6,272	3.07
3.08	30.00	ADULTS & PEDIATRICS	RELATED PARTY SVCS	200,744	200,744	3.08
3.09	50.00	OPERATING ROOM	RELATED PARTY SVCS	441	441	3.09
3.10	53.00	ANESTHESIOLOGY	RELATED PARTY SVCS	81	81	3.10
3.11	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SVCS	1,169	1,169	3.11
3.12	57.00	CT SCAN	RELATED PARTY SVCS	1,690	1,690	3.12
3.13	60.00	LABORATORY	RELATED PARTY SVCS	182,452	182,452	3.13
3.14	65.00	RESPIRATORY THERAPY	RELATED PARTY SVCS	101,654	101,654	3.14
3.15	66.00	PHYSICAL THERAPY	RELATED PARTY SVCS	184	184	3.15
3.16	71.00	MEDICAL SUPPLIES CHARGED TO	RELATED PARTY SVCS	69	69	3.16
3.17	76.97	CARDIAC REHABILITATION	RELATED PARTY SVCS	5,247	5,247	3.17
3.18	90.00	CLINIC	RELATED PARTY SVCS	87,428	87,428	3.18
3.19	91.00	EMERGENCY	RELATED PARTY SVCS	13	13	3.19
3.20	190.00	GIFT, FLOWER, COFFEE SHOP &	RELATED PARTY SVCS	8,000	8,000	3.20
3.21	192.00	PHYSICIANS' PRIVATE OFFICES	RELATED PARTY SVCS	11	11	3.21
3.22	194.00	OTHER NONALLOWABLE	RELATED PARTY SVCS	3,209	3,209	3.22
3.23	0.00			0	0	3.23
3.24	0.00			0	0	3.24
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,972,926	6,902,155	5.00

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

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/16/2018 10:51 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-24,342	0		1.00
2.00	0	0		2.00
3.00	1,095,113	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
3.18	0	0		3.18
3.19	0	0		3.19
3.20	0	0		3.20
3.21	0	0		3.21
3.22	0	0		3.22
3.23	0	0		3.23
3.24	0	0		3.24
4.00	0	0		4.00
5.00	1,070,771			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	CORPORATE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/16/2018 10:51 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	53.00	ANESTHESIOLOGY	439,273	439,273	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	111,495	111,495	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	150	150	0	0	0	3.00
4.00	91.00	EMERGENCY	1,417,447	203,987	1,213,460	0	0	4.00
5.00	90.00	CLINIC	757,430	757,430	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	179,037	179,037	0	0	0	6.00
7.00	5.03	ADMINISTRATIVE & GENERAL	121,713	0	121,713	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,026,545	1,691,372	1,335,173		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	439,273		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	111,495		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	150		3.00
4.00	91.00	EMERGENCY	0	0	0	203,987		4.00
5.00	90.00	CLINIC	0	0	0	757,430		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	179,037		6.00
7.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,691,372		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/16/2018 10:51 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)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						7.47	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	2,287.00	2,834.75	4,667.75	0.00	0.00		9.00
10.00	AHSEA (see instructions)	109.92	81.42	61.07	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)	40.71	40.71	30.54				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)						251,387	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						230,805	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						285,059	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						767,251	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)						767,251	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)						767,251	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						0	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/16/2018 10:51 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)	81.42	61.07	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)	767,251		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	767,251		63.00
64.00	Total cost of outside supplier services (from your records)	701,663		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

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		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)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		7.47	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	548.00	156.56	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.18	57.89	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)	38.59	38.59	28.95			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	42,295	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	9,063	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	51,358	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)	51,358	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)	72.89	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	56,854	22.00
23.00	Total salary equivalency (see instructions)	56,854	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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		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)	77.18	57.89	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)	56,854	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	56,854	63.00
64.00	Total cost of outside supplier services (from your records)	42,297	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

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Speech Pathology — Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						7.47	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	155.75	0.00	0.00	0.00		9.00
10.00	AHSEA (see instructions)	0.00	74.17	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)	37.09	37.09	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)						11,552	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)						11,552	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)						11,552	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)						74.17	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						57,853	22.00
23.00	Total salary equivalency (see instructions)						57,853	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						0	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1350	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/16/2018 10:51 am

Speech Pathology — Cost

							1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
	PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00			48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00			49.00
	CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00
	DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.17	0.00	0.00	0.00			52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	57,853		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	57,853		63.00
64.00	Total cost of outside supplier services (from your records)	9,318		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/16/2018 10:51 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	1,888,552	1,888,552				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	379,582		379,582			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,973,155	4,842	1,773	4,979,770		4.00
5.01	00570	ADMITTING	391,169	32,025	836	159,825	583,855	5.01
5.02	00540	PATIENT ACCOUNTING	561,121	2,486	0	0	0	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	6,510,551	191,978	6,327	522,773	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	317,576	0	0	127,293	0	6.00
7.00	00700	OPERATION OF PLANT	1,193,912	403,628	0	29,974	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	127,580	16,400	0	0	0	8.00
9.00	00900	HOUSEKEEPING	504,419	35,641	354	119,393	0	9.00
10.00	01000	DIETARY	106,584	97,151	3,510	27,261	0	10.00
11.00	01100	CAFETERIA	470,910	31,767	0	120,291	0	11.00
13.00	01300	NURSING ADMINISTRATION	175,791	5,789	6,436	73,198	0	13.00
15.00	01500	PHARMACY	752,794	20,252	12,805	219,524	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	614,575	20,812	0	149,272	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,022,533	206,376	65,897	824,157	25,984	30.00
43.00	04300	NURSERY	110,074	9,470	0	46,149	1,374	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,173,577	158,339	69,284	481,206	39,251	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	562,242	46,305	0	235,723	7,037	52.00
53.00	05300	ANESTHESIOLOGY	86,827	5,079	2,986	0	31,169	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,217,319	97,539	50,027	395,438	71,020	54.00
57.00	05700	CT SCAN	315,251	5,736	3,307	49,826	89,813	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	240,977	19,036	120,775	44,474	32,908	58.00
60.00	06000	LABORATORY	1,924,459	51,287	7,274	320,387	75,956	60.00
65.00	06500	RESPIRATORY THERAPY	469,736	34,909	5,941	159,965	11,094	65.00
66.00	06600	PHYSICAL THERAPY	912,770	53,364	1,322	58,652	30,208	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	257,220	27,204	0	0	16,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	414,842	0	0	0	10,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,745,236	0	0	0	59,777	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	216,182	15,195	0	84,287	14,140	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	352,434	25,515	1,104	103,191	12,165	90.00
91.00	09100	EMERGENCY	2,485,923	85,788	19,587	543,688	55,698	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,475,873	1,703,913	379,545	4,895,947	583,855	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39,571	10,105	37	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	544,883	174,534	0	55,710	0	192.00
194.00	07950	OTHER NONALLOWABLE	119,643	0	0	28,113	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,179,970	1,888,552	379,582	4,979,770	583,855	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/16/2018 10:51 am

		Cost Center Description	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5A.02	5.03	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING	563,607					5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	7,231,629	7,231,629			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	444,869	115,110	559,979		6.00
7.00	00700	OPERATION OF PLANT	0	1,627,514	421,119	136,388	2,185,021	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,980	37,255	5,542	28,585	8.00
9.00	00900	HOUSEKEEPING	0	659,807	170,725	12,043	62,122	9.00
10.00	01000	DIETARY	0	234,506	60,678	32,828	169,335	10.00
11.00	01100	CAFETERIA	0	622,968	161,193	10,734	55,370	11.00
13.00	01300	NURSING ADMINISTRATION	0	261,214	67,589	1,956	10,091	13.00
15.00	01500	PHARMACY	0	1,005,375	260,141	6,843	35,300	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	784,659	203,031	7,032	36,275	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,088	3,170,035	820,247	69,735	359,717	30.00
43.00	04300	NURSERY	1,327	168,394	43,572	3,200	16,506	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,896	2,959,553	765,784	53,503	275,986	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,794	858,101	222,034	15,647	80,710	52.00
53.00	05300	ANESTHESIOLOGY	30,094	156,155	40,405	1,716	8,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,569	1,899,912	491,602	32,959	170,010	54.00
57.00	05700	CT SCAN	86,615	550,548	142,454	1,938	9,997	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	31,772	489,942	126,772	6,432	33,181	58.00
60.00	06000	LABORATORY	73,335	2,452,698	634,636	17,330	89,394	60.00
65.00	06500	RESPIRATORY THERAPY	10,711	692,356	179,147	11,796	60,847	65.00
66.00	06600	PHYSICAL THERAPY	29,165	1,085,481	280,868	18,032	93,014	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,634	316,251	81,830	9,192	47,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,720	434,630	112,461	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,714	1,862,727	481,981	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	13,652	343,456	88,869	5,134	26,484	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,745	506,154	130,967	8,621	44,472	90.00
91.00	09100	EMERGENCY	53,776	3,244,460	839,500	28,988	149,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	563,607	34,207,374	6,979,970	497,589	1,863,194	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49,713	12,863	3,414	17,613	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	775,127	200,564	58,976	304,214	192.00
194.00	07950	OTHER NONALLOWABLE	0	147,756	38,232	0	0	194.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	563,607	35,179,970	7,231,629	559,979	2,185,021	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/16/2018 10:51 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	215,362					8.00
9.00	00900	HOUSEKEEPING	0	904,697				9.00
10.00	01000	DIETARY	0	0	497,347			10.00
11.00	01100	CAFETERIA	0	0	0	850,265		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,608	0	5,937	351,395	13.00
15.00	01500	PHARMACY	0	8,492	0	28,046	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	38,677	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	88,431	190,353	497,347	205,768	158,671	30.00
43.00	04300	NURSERY	4,134	9,938	0	7,803	6,017	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,095	131,449	0	96,239	74,212	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,223	50,908	0	40,090	30,914	52.00
53.00	05300	ANESTHESIOLOGY	0	7,634	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,804	69,745	0	84,591	0	54.00
57.00	05700	CT SCAN	6,565	6,505	0	10,348	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,072	0	0	7,125	0	58.00
60.00	06000	LABORATORY	0	47,204	0	64,913	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,646	21,547	0	35,397	0	65.00
66.00	06600	PHYSICAL THERAPY	887	9,893	0	45,236	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,770	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	18,520	0	11,874	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,309	28,142	0	25,954	0	90.00
91.00	09100	EMERGENCY	32,776	127,384	0	105,795	81,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	209,942	740,092	497,347	813,793	351,395	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,794	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,420	160,811	0	22,901	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	13,571	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	215,362	904,697	497,347	850,265	351,395	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/16/2018 10:51 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	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	1,344,197					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,069,674				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	256,948	0	5,817,252	0	30.00
43.00	04300	NURSERY	0	14,388	0	273,952	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	150,026	0	4,533,847	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	73,491	0	1,393,118	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	214,763	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	123,286	0	2,889,909	0	54.00
57.00	05700	CT SCAN	0	15,534	0	743,889	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,866	0	680,390	0	58.00
60.00	06000	LABORATORY	0	99,887	0	3,406,062	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	49,872	0	1,054,608	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,286	0	1,551,697	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	462,460	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	547,091	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,344,197	0	0	3,688,905	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	26,278	0	520,615	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	32,172	0	780,791	0	90.00
91.00	09100	EMERGENCY	0	169,506	0	4,779,518	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,344,197	1,043,540	0	33,338,867	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	87,397	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,369	0	1,545,382	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	8,765	0	208,324	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,344,197	1,069,674	0	35,179,970	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/16/2018 10:51 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	00540	PATIENT ACCOUNTING			5.02
5.03	00550	ADMINISTRATIVE & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,817,252		30.00
43.00	04300	NURSERY	273,952		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	4,533,847		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,393,118		52.00
53.00	05300	ANESTHESIOLOGY	214,763		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,889,909		54.00
57.00	05700	CT SCAN	743,889		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	680,390		58.00
60.00	06000	LABORATORY	3,406,062		60.00
65.00	06500	RESPIRATORY THERAPY	1,054,608		65.00
66.00	06600	PHYSICAL THERAPY	1,551,697		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	462,460		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	547,091		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,688,905		73.00
76.00	03020	OTHER	0		76.00
76.97	07697	CARDIAC REHABILITATION	520,615		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	780,791		90.00
91.00	09100	EMERGENCY	4,779,518		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,338,867		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	87,397		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,545,382		192.00
194.00	07950	OTHER NONALLOWABLE	208,324		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	35,179,970		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/16/2018 10:51 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	754	4,842	1,773	7,369	7,369	4.00
5.01	00570	ADMITTING	3,662	32,025	836	36,523	237	5.01
5.02	00540	PATIENT ACCOUNTING	0	2,486	0	2,486	0	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	1,462,092	191,978	6,327	1,660,397	774	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	188	6.00
7.00	00700	OPERATION OF PLANT	7,688	403,628	0	411,316	44	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,400	0	16,400	0	8.00
9.00	00900	HOUSEKEEPING	480	35,641	354	36,475	177	9.00
10.00	01000	DIETARY	480	97,151	3,510	101,141	40	10.00
11.00	01100	CAFETERIA	0	31,767	0	31,767	178	11.00
13.00	01300	NURSING ADMINISTRATION	240	5,789	6,436	12,465	108	13.00
15.00	01500	PHARMACY	92,691	20,252	12,805	125,748	325	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,073	20,812	0	25,885	221	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,977	206,376	65,897	278,250	1,216	30.00
43.00	04300	NURSERY	0	9,470	0	9,470	68	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,546	158,339	69,284	236,169	713	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	46,305	0	46,305	349	52.00
53.00	05300	ANESTHESIOLOGY	1,475	5,079	2,986	9,540	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,754	97,539	50,027	150,320	586	54.00
57.00	05700	CT SCAN	0	5,736	3,307	9,043	74	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,036	120,775	139,811	66	58.00
60.00	06000	LABORATORY	86,801	51,287	7,274	145,362	474	60.00
65.00	06500	RESPIRATORY THERAPY	21,017	34,909	5,941	61,867	237	65.00
66.00	06600	PHYSICAL THERAPY	935	53,364	1,322	55,621	87	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,049	27,204	0	39,253	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,175	15,195	0	16,370	125	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	25,515	1,104	26,619	153	90.00
91.00	09100	EMERGENCY	3,671	85,788	19,587	109,046	805	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,717,560	1,703,913	379,545	3,801,018	7,245	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	76	10,105	37	10,218	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,023	174,534	0	183,557	82	192.00
194.00	07950	OTHER NONALLOWABLE	7,800	0	0	7,800	42	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,734,459	1,888,552	379,582	4,002,593	7,369	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/16/2018 10:51 am

		Cost Center Description	ADMITTING	PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.01	5.02	5.03	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	36,760					5.01
5.02	00540	PATIENT ACCOUNTING	0	2,486				5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	0	1,661,171			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	26,442	26,630		6.00
7.00	00700	OPERATION OF PLANT	0	0	96,735	6,487	514,582	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8,558	264	6,732	8.00
9.00	00900	HOUSEKEEPING	0	0	39,217	573	14,630	9.00
10.00	01000	DIETARY	0	0	13,938	1,561	39,879	10.00
11.00	01100	CAFETERIA	0	0	37,027	510	13,040	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	15,526	93	2,376	13.00
15.00	01500	PHARMACY	0	0	59,756	325	8,313	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	46,638	334	8,543	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,636	110	188,417	3,316	84,715	30.00
43.00	04300	NURSERY	87	6	10,009	152	3,887	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,471	166	175,907	2,544	64,996	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	443	30	51,003	744	19,008	52.00
53.00	05300	ANESTHESIOLOGY	1,963	132	9,281	82	2,085	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,472	301	112,925	1,567	40,038	54.00
57.00	05700	CT SCAN	5,651	392	32,723	92	2,354	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,072	139	29,121	306	7,814	58.00
60.00	06000	LABORATORY	4,783	322	145,781	824	21,053	60.00
65.00	06500	RESPIRATORY THERAPY	699	47	41,152	561	14,330	65.00
66.00	06600	PHYSICAL THERAPY	1,902	128	64,518	858	21,905	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,020	69	18,797	437	11,167	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	634	43	25,833	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,764	253	110,715	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	890	60	20,414	244	6,237	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	766	52	30,084	410	10,473	90.00
91.00	09100	EMERGENCY	3,507	236	192,846	1,379	35,215	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,760	2,486	1,603,363	23,663	438,790	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,955	162	4,148	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	46,071	2,805	71,644	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	8,782	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,760	2,486	1,661,171	26,630	514,582	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/16/2018 10:51 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,954					8.00
9.00	00900	HOUSEKEEPING	0	91,072				9.00
10.00	01000	DIETARY	0	0	156,559			10.00
11.00	01100	CAFETERIA	0	0	0	82,522		11.00
13.00	01300	NURSING ADMINISTRATION	0	464	0	576	31,608	13.00
15.00	01500	PHARMACY	0	855	0	2,722	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,754	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,121	19,163	156,559	19,973	14,273	30.00
43.00	04300	NURSERY	613	1,000	0	757	541	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,020	13,232	0	9,340	6,675	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,149	5,125	0	3,891	2,781	52.00
53.00	05300	ANESTHESIOLOGY	0	768	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,642	7,021	0	8,210	0	54.00
57.00	05700	CT SCAN	974	655	0	1,004	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	456	0	0	691	0	58.00
60.00	06000	LABORATORY	0	4,752	0	6,300	0	60.00
65.00	06500	RESPIRATORY THERAPY	541	2,169	0	3,435	0	65.00
66.00	06600	PHYSICAL THERAPY	132	996	0	4,390	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	782	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,864	0	1,152	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	639	2,833	0	2,519	0	90.00
91.00	09100	EMERGENCY	4,863	12,823	0	10,268	7,338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,150	74,502	156,559	78,982	31,608	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	382	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	804	16,188	0	2,223	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	1,317	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,954	91,072	156,559	82,522	31,608	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/16/2018 10:51 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	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	198,044					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	85,375				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	20,509	0	801,258	0	30.00
43.00	04300	NURSERY	0	1,148	0	27,738	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,974	0	528,207	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,866	0	138,694	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	23,851	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,840	0	337,922	0	54.00
57.00	05700	CT SCAN	0	1,240	0	54,202	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,107	0	181,583	0	58.00
60.00	06000	LABORATORY	0	7,972	0	337,623	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,980	0	129,018	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,459	0	151,996	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71,525	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,510	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	198,044	0	0	312,776	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,097	0	49,453	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,568	0	77,116	0	90.00
91.00	09100	EMERGENCY	0	13,529	0	391,855	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	198,044	83,289	0	3,641,327	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	17,865	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,386	0	324,760	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	700	0	18,641	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	198,044	85,375	0	4,002,593	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00540	PATIENT ACCOUNTING			5.02
5.03	00550	ADMINISTRATIVE & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	801,258		30.00
43.00	04300	NURSERY	27,738		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	528,207		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	138,694		52.00
53.00	05300	ANESTHESIOLOGY	23,851		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	337,922		54.00
57.00	05700	CT SCAN	54,202		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	181,583		58.00
60.00	06000	LABORATORY	337,623		60.00
65.00	06500	RESPIRATORY THERAPY	129,018		65.00
66.00	06600	PHYSICAL THERAPY	151,996		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,525		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,510		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	312,776		73.00
76.00	03020	OTHER	0		76.00
76.97	07697	CARDIAC REHABILITATION	49,453		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	77,116		90.00
91.00	09100	EMERGENCY	391,855		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,641,327		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,865		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	324,760		192.00
194.00	07950	OTHER NONALLOWABLE	18,641		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	4,002,593		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/16/2018 10:51 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	175,498					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,200,642				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	450	5,607	11,326,561			4.00
5.01	00570	ADMITTING	2,976	2,645	363,525	117,820,279		5.01
5.02	00540	PATIENT ACCOUNTING	231	0	0	0	117,820,279	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	17,840	20,014	1,189,056	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	289,530	0	0	6.00
7.00	00700	OPERATION OF PLANT	37,508	0	68,177	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,524	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,312	1,121	271,562	0	0	9.00
10.00	01000	DIETARY	9,028	11,101	62,005	0	0	10.00
11.00	01100	CAFETERIA	2,952	0	273,603	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	538	20,358	166,490	0	0	13.00
15.00	01500	PHARMACY	1,882	40,504	499,311	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,934	0	339,522	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,178	208,435	1,874,554	5,244,083	5,244,083	30.00
43.00	04300	NURSERY	880	0	104,966	277,386	277,386	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,714	219,149	1,094,510	7,921,405	7,921,405	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,303	0	536,155	1,420,149	1,420,149	52.00
53.00	05300	ANESTHESIOLOGY	472	9,444	0	6,290,493	6,290,493	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,064	158,239	899,431	14,333,025	14,333,025	54.00
57.00	05700	CT SCAN	533	10,459	113,331	18,114,275	18,114,275	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,769	382,023	101,156	6,641,370	6,641,370	58.00
60.00	06000	LABORATORY	4,766	23,007	728,725	15,329,155	15,329,155	60.00
65.00	06500	RESPIRATORY THERAPY	3,244	18,792	363,844	2,238,947	2,238,947	65.00
66.00	06600	PHYSICAL THERAPY	4,959	4,180	133,405	6,096,459	6,096,459	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,528	0	0	3,268,060	3,268,060	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,031,857	2,031,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,064,062	12,064,062	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,412	0	191,711	2,853,700	2,853,700	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,371	3,492	234,710	2,455,144	2,455,144	90.00
91.00	09100	EMERGENCY	7,972	61,954	1,236,626	11,240,709	11,240,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	158,340	1,200,524	11,135,905	117,820,279	117,820,279	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	939	118	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,219	0	126,713	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	63,943	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,888,552	379,582	4,979,770	583,855	563,607	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.761103	0.316149	0.439654	0.004955	0.004784	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,369	36,760	2,486	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000651	0.000312	0.000021	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: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/16/2018 10:51 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5A.03	5.03	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-7,231,629	27,948,341				5.03
6.00	00600	MAINTENANCE & REPAIRS	0	444,869	154,001			6.00
7.00	00700	OPERATION OF PLANT	0	1,627,514	37,508	116,493		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,980	1,524	1,524	192,508	8.00
9.00	00900	HOUSEKEEPING	0	659,807	3,312	3,312	0	9.00
10.00	01000	DIETARY	0	234,506	9,028	9,028	0	10.00
11.00	01100	CAFETERIA	0	622,968	2,952	2,952	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	261,214	538	538	0	13.00
15.00	01500	PHARMACY	0	1,005,375	1,882	1,882	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	784,659	1,934	1,934	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,170,035	19,178	19,178	79,046	30.00
43.00	04300	NURSERY	0	168,394	880	880	3,695	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,959,553	14,714	14,714	24,220	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	858,101	4,303	4,303	18,971	52.00
53.00	05300	ANESTHESIOLOGY	0	156,155	472	472	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,899,912	9,064	9,064	15,915	54.00
57.00	05700	CT SCAN	0	550,548	533	533	5,868	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	489,942	1,769	1,769	2,746	58.00
60.00	06000	LABORATORY	0	2,452,698	4,766	4,766	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	692,356	3,244	3,244	3,259	65.00
66.00	06600	PHYSICAL THERAPY	0	1,085,481	4,959	4,959	793	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	316,251	2,528	2,528	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	434,630	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,862,727	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	343,456	1,412	1,412	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	506,154	2,371	2,371	3,852	90.00
91.00	09100	EMERGENCY	0	3,244,460	7,972	7,972	29,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,231,629	26,975,745	136,843	99,335	187,663	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49,713	939	939	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	775,127	16,219	16,219	4,845	192.00
194.00	07950	OTHER NONALLOWABLE	0	147,756	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		7,231,629	559,979	2,185,021	215,362	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.258750	3.636204	18.756672	1.118717	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,661,171	26,630	514,582	31,954	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.059437	0.172921	4.417278	0.165988	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: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/16/2018 10:51 am

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	20,028					9.00
10.00	01000	DIETARY	0	24,041				10.00
11.00	01100	CAFETERIA	0	0	15,037			11.00
13.00	01300	NURSING ADMINISTRATION	102	0	105	8,059		13.00
15.00	01500	PHARMACY	188	0	496	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	684	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,214	24,041	3,639	3,639	0	30.00
43.00	04300	NURSERY	220	0	138	138	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,910	0	1,702	1,702	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,127	0	709	709	0	52.00
53.00	05300	ANESTHESIOLOGY	169	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,544	0	1,496	0	0	54.00
57.00	05700	CT SCAN	144	0	183	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	126	0	0	58.00
60.00	06000	LABORATORY	1,045	0	1,148	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	477	0	626	0	0	65.00
66.00	06600	PHYSICAL THERAPY	219	0	800	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	172	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	100	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	410	0	210	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	623	0	459	0	0	90.00
91.00	09100	EMERGENCY	2,820	0	1,871	1,871	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,384	24,041	14,392	8,059	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	84	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,560	0	405	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	240	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	904,697	497,347	850,265	351,395	1,344,197	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	45.171610	20.687451	56.544856	43.602804	13,441.970000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	91,072	156,559	82,522	31,608	198,044	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.547234	6.512167	5.487930	3.922075	1,980.440000	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: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/16/2018 10:51 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS SALARIES)	SOCIAL SERVICE (TIME SPENT)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00540	PATIENT ACCOUNTING				5.02
5.03	00550	ADMINISTRATIVE & GENERAL				5.03
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,803,780			16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,874,554	0		30.00
43.00	04300	NURSERY	104,966	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,094,510	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	536,155	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	899,431	0		54.00
57.00	05700	CT SCAN	113,331	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	101,156	0		58.00
60.00	06000	LABORATORY	728,725	0		60.00
65.00	06500	RESPIRATORY THERAPY	363,844	0		65.00
66.00	06600	PHYSICAL THERAPY	133,405	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	191,711	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	234,710	0		90.00
91.00	09100	EMERGENCY	1,236,626	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,613,124	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126,713	0		192.00
194.00	07950	OTHER NONALLOWABLE	63,943	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,069,674	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.137071	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	85,375	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.010940	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/16/2018 10:51 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	5,817,252		5,817,252	0	0	30.00
43.00	04300	NURSERY	273,952		273,952	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,533,847		4,533,847	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,393,118		1,393,118	0	0	52.00
53.00	05300	ANESTHESIOLOGY	214,763		214,763	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,889,909		2,889,909	0	0	54.00
57.00	05700	CT SCAN	743,889		743,889	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	680,390		680,390	0	0	58.00
60.00	06000	LABORATORY	3,406,062		3,406,062	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,054,608	0	1,054,608	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,551,697	0	1,551,697	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	462,460		462,460	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	547,091		547,091	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,688,905		3,688,905	0	0	73.00
76.00	03020	OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	520,615		520,615	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	780,791		780,791	0	0	90.00
91.00	09100	EMERGENCY	4,779,518		4,779,518	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	779,865		779,865		0	92.00
200.00		Subtotal (see instructions)	34,118,732	0	34,118,732	0	0	200.00
201.00		Less Observation Beds	779,865		779,865		0	201.00
202.00		Total (see instructions)	33,338,867	0	33,338,867	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/16/2018 10:51 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	4,326,487		4,326,487			30.00
43.00	04300	NURSERY	277,386		277,386			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,280,698	6,640,707	7,921,405	0.572354	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	459,207	960,942	1,420,149	0.980966	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,266,974	5,023,519	6,290,493	0.034141	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,178,768	13,154,257	14,333,025	0.201626	0.000000	54.00
57.00	05700	CT SCAN	1,576,489	16,537,786	18,114,275	0.041066	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	194,061	6,447,309	6,641,370	0.102447	0.000000	58.00
60.00	06000	LABORATORY	3,669,225	11,659,930	15,329,155	0.222195	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	555,433	1,683,514	2,238,947	0.471029	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,238,123	4,858,336	6,096,459	0.254524	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,290,590	1,977,470	3,268,060	0.141509	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,483,303	548,554	2,031,857	0.269257	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,302,269	8,761,793	12,064,062	0.305776	0.000000	73.00
76.00	03020	OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	223,887	2,629,813	2,853,700	0.182435	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,221	2,453,923	2,455,144	0.318022	0.000000	90.00
91.00	09100	EMERGENCY	1,341,010	9,899,699	11,240,709	0.425197	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	255,598	661,998	917,596	0.849900	0.000000	92.00
200.00		Subtotal (see instructions)	23,920,729	93,899,550	117,820,279			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,920,729	93,899,550	117,820,279			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/16/2018 10:51 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OTHER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/16/2018 10:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,817,252		5,817,252	0	5,817,252	30.00
43.00	04300	NURSERY	273,952		273,952	0	273,952	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,533,847		4,533,847	0	4,533,847	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,393,118		1,393,118	0	1,393,118	52.00
53.00	05300	ANESTHESIOLOGY	214,763		214,763	0	214,763	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,889,909		2,889,909	0	2,889,909	54.00
57.00	05700	CT SCAN	743,889		743,889	0	743,889	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	680,390		680,390	0	680,390	58.00
60.00	06000	LABORATORY	3,406,062		3,406,062	0	3,406,062	60.00
65.00	06500	RESPIRATORY THERAPY	1,054,608	0	1,054,608	0	1,054,608	65.00
66.00	06600	PHYSICAL THERAPY	1,551,697	0	1,551,697	0	1,551,697	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	462,460		462,460	0	462,460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	547,091		547,091	0	547,091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,688,905		3,688,905	0	3,688,905	73.00
76.00	03020	OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	520,615		520,615	0	520,615	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	780,791		780,791	0	780,791	90.00
91.00	09100	EMERGENCY	4,779,518		4,779,518	0	4,779,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	779,865		779,865		779,865	92.00
200.00		Subtotal (see instructions)	34,118,732	0	34,118,732	0	34,118,732	200.00
201.00		Less Observation Beds	779,865		779,865		779,865	201.00
202.00		Total (see instructions)	33,338,867	0	33,338,867	0	33,338,867	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/16/2018 10:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,326,487		4,326,487			30.00
43.00	04300	NURSERY	277,386		277,386			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,280,698	6,640,707	7,921,405	0.572354	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	459,207	960,942	1,420,149	0.980966	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,266,974	5,023,519	6,290,493	0.034141	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,178,768	13,154,257	14,333,025	0.201626	0.000000	54.00
57.00	05700	CT SCAN	1,576,489	16,537,786	18,114,275	0.041066	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	194,061	6,447,309	6,641,370	0.102447	0.000000	58.00
60.00	06000	LABORATORY	3,669,225	11,659,930	15,329,155	0.222195	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	555,433	1,683,514	2,238,947	0.471029	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,238,123	4,858,336	6,096,459	0.254524	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,290,590	1,977,470	3,268,060	0.141509	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,483,303	548,554	2,031,857	0.269257	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,302,269	8,761,793	12,064,062	0.305776	0.000000	73.00
76.00	03020	OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	223,887	2,629,813	2,853,700	0.182435	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,221	2,453,923	2,455,144	0.318022	0.000000	90.00
91.00	09100	EMERGENCY	1,341,010	9,899,699	11,240,709	0.425197	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	255,598	661,998	917,596	0.849900	0.000000	92.00
200.00		Subtotal (see instructions)	23,920,729	93,899,550	117,820,279			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,920,729	93,899,550	117,820,279			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/16/2018 10:51 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OTHER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/16/2018 10:51 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	528,207	7,921,405	0.066681	651,185	43,422	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	138,694	1,420,149	0.097662	1,781	174	52.00
53.00	05300	ANESTHESIOLOGY	23,851	6,290,493	0.003792	665,987	2,525	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	337,922	14,333,025	0.023576	578,452	13,638	54.00
57.00	05700	CT SCAN	54,202	18,114,275	0.002992	421,549	1,261	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	181,583	6,641,370	0.027341	91,332	2,497	58.00
60.00	06000	LABORATORY	337,623	15,329,155	0.022025	1,342,394	29,566	60.00
65.00	06500	RESPIRATORY THERAPY	129,018	2,238,947	0.057624	321,172	18,507	65.00
66.00	06600	PHYSICAL THERAPY	151,996	6,096,459	0.024932	630,357	15,716	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,525	3,268,060	0.021886	535,574	11,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,510	2,031,857	0.013047	1,016,824	13,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	312,776	12,064,062	0.025926	1,250,175	32,412	73.00
76.00	03020	OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	49,453	2,853,700	0.017329	57,645	999	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	77,116	2,455,144	0.031410	58	2	90.00
91.00	09100	EMERGENCY	391,855	11,240,709	0.034860	5,506	192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	107,417	917,596	0.117064	0	0	92.00
200.00		Total (lines 50 through 199)	2,919,748	113,216,406		7,569,991	185,900	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/16/2018 10:51 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/16/2018 10:51 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	7,921,405	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,420,149	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,290,493	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,333,025	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	18,114,275	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	6,641,370	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	15,329,155	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,238,947	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,096,459	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,268,060	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,031,857	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,064,062	0.000000	73.00
76.00	03020	OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,853,700	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,455,144	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	11,240,709	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	917,596	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	113,216,406		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/16/2018 10:51 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	651,185	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	1,781	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	665,987	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	578,452	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	421,549	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	91,332	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,342,394	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	321,172	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	630,357	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	535,574	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,016,824	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,250,175	0	0	0	73.00
76.00	03020	OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	57,645	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	58	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	5,506	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)		7,569,991	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/16/2018 10:51 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	0.572354	0	2,296,949	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.980966	0	3,253	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.034141	0	1,565,986	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201626	0	5,728,923	0	0	54.00
57.00	05700	CT SCAN	0.041066	0	7,576,519	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.102447	0	2,245,262	0	0	58.00
60.00	06000	LABORATORY	0.222195	0	5,662,600	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.471029	0	729,906	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.254524	0	1,817,944	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.141509	0	856,063	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.269257	0	157,931	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305776	0	4,742,270	5,788	0	73.00
76.00	03020	OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.182435	0	1,376,492	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.318022	0	801,604	0	0	90.00
91.00	09100	EMERGENCY	0.425197	0	3,937,561	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.849900	0	485,568	0	0	92.00
200.00		Subtotal (see instructions)		0	39,984,831	5,788	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	39,984,831	5,788	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/16/2018 10:51 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	1,314,668	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,191	0		52.00
53.00	05300	ANESTHESIOLOGY	53,464	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,155,100	0		54.00
57.00	05700	CT SCAN	311,137	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,020	0		58.00
60.00	06000	LABORATORY	1,258,201	0		60.00
65.00	06500	RESPIRATORY THERAPY	343,807	0		65.00
66.00	06600	PHYSICAL THERAPY	462,710	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	121,141	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,524	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,450,072	1,770		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	251,120	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	254,928	0		90.00
91.00	09100	EMERGENCY	1,674,239	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	412,684	0		92.00
200.00		Subtotal (see instructions)	9,339,006	1,770		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,339,006	1,770		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/16/2018 10:51 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.572354	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.980966	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.034141	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201626	0	0	0	0	54.00
57.00	05700	CT SCAN	0.041066	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.102447	0	0	0	0	58.00
60.00	06000	LABORATORY	0.222195	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.471029	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.254524	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.141509	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.269257	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305776	0	0	0	0	73.00
76.00	03020	OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.182435	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.318022	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.425197	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.849900	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/16/2018 10:51 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/16/2018 10:51 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)	4,990	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,387	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)	3,722	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	285	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)	284	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	17	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)	17	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,346	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)	266	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)	265	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	153.39	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	153.39	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,817,252	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)	2,608	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)	2,608	25.00
26.00	Total swing-bed cost (see instructions)	672,499	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,144,753	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,144,753	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,172.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,751,225	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,751,225	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/16/2018 10:51 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,895,211	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,646,436	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)	311,946	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	310,773	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	622,719	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)	665	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,172.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	779,865	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/16/2018 10:51 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	801,258	5,817,252	0.137738	779,865	107,417	90.00
91.00	Nursing School cost	0	5,817,252	0.000000	779,865	0	91.00
92.00	Allied health cost	0	5,817,252	0.000000	779,865	0	92.00
93.00	All other Medical Education	0	5,817,252	0.000000	779,865	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/16/2018 10:51 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		2,085,762		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.572354	651,185	372,708	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.980966	1,781	1,747	52.00
53.00	05300	ANESTHESIOLOGY	0.034141	665,987	22,737	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201626	578,452	116,631	54.00
57.00	05700	CT SCAN	0.041066	421,549	17,311	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.102447	91,332	9,357	58.00
60.00	06000	LABORATORY	0.222195	1,342,394	298,273	60.00
65.00	06500	RESPIRATORY THERAPY	0.471029	321,172	151,281	65.00
66.00	06600	PHYSICAL THERAPY	0.254524	630,357	160,441	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.141509	535,574	75,789	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.269257	1,016,824	273,787	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305776	1,250,175	382,274	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.182435	57,645	10,516	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.318022	58	18	90.00
91.00	09100	EMERGENCY	0.425197	5,506	2,341	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.849900	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,569,991	1,895,211	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		7,569,991		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3

Component CCN: 14-Z350 | Date/Time Prepared: 11/16/2018 10:51 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.572354	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.980966	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.034141	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201626	16,042	3,234	54.00
57.00	05700	CT SCAN	0.041066	2,103	86	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.102447	0	0	58.00
60.00	06000	LABORATORY	0.222195	131,415	29,200	60.00
65.00	06500	RESPIRATORY THERAPY	0.471029	34,317	16,164	65.00
66.00	06600	PHYSICAL THERAPY	0.254524	336,438	85,632	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.141509	51,108	7,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.269257	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305776	137,027	41,900	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.182435	2,041	372	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.318022	0	0	90.00
91.00	09100	EMERGENCY	0.425197	546	232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.849900	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		711,037	184,052	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)		711,037		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/16/2018 10:51 am

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.572354	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.980966	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.034141	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201626	0	0	54.00
57.00	05700	CT SCAN	0.041066	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.102447	0	0	58.00
60.00	06000	LABORATORY	0.222195	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.471029	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.254524	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.141509	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.269257	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305776	0	0	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.182435	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.318022	0	0	90.00
91.00	09100	EMERGENCY	0.425197	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.849900	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1350	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/16/2018 10:51 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,340,776	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)	9,340,776	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)	9,434,184	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)	86,062	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	6,965,615	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)	2,382,507	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)	2,382,507	30.00
31.00	Primary payer payments	224	31.00
32.00	Subtotal (line 30 minus line 31)	2,382,283	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,410,366	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	916,738	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	980,976	36.00
37.00	Subtotal (see instructions)	3,299,021	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,299,021	40.00
40.01	Sequestration adjustment (see instructions)	65,980	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,783,547	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	449,494	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 11/16/2018 10:51 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		4,207,071		2,946,564	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/01/2018	197,332		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	02/01/2018	122,602	3.50
3.51			0	06/18/2018	40,415	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)		197,332		-163,017	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,404,403		2,783,547	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		449,494	6.01
6.02	SETTLEMENT TO PROGRAM		176,482		0	6.02
7.00	Total Medicare program liability (see instructions)		4,227,921		3,233,041	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/16/2018 10:51 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		731,182		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/01/2018	34,328		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)		34,328		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)		765,510		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		28,480		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		793,990		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1350	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/16/2018 10:51 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: 14-1350 | Component CCN: 14-Z350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-2 | Date/Time Prepared: 11/16/2018 10:51 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	628,946	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)	185,893	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	531	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)	814,839	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	814,839	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)	814,839	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,645	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)	810,194	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)	810,194	0	19.00
19.01	Sequestration adjustment (see instructions)	16,204	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	765,510	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)	28,480	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 - SWING BEDS	Provider CCN: 14-1350 Component CCN: 14-Z350	Period: From 07/01/2017 To 06/30/2018	Worksheet E-2 Date/Time Prepared: 11/16/2018 10:51 am
	Title XIX	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	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: 14-1350	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/16/2018 10:51 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,646,436	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	4,646,436	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,692,900	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,692,900	19.00
20.00	Deductibles (exclude professional component)	633,487	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,059,413	22.00
23.00	Coinsurance	11,701	23.00
24.00	Subtotal (line 22 minus line 23)	4,047,712	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	409,989	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	266,493	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	362,739	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,314,205	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)	4,314,205	30.00
30.01	Sequestration adjustment (see instructions)	86,284	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	4,404,403	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)	-176,482	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/16/2018 10:51 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	4,321,382	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,774,885	0	0	0	4.00
5.00	Other receivable	27,831	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,904,678	0	0	0	6.00
7.00	Inventory	462,222	0	0	0	7.00
8.00	Prepaid expenses	143,750	0	0	0	8.00
9.00	Other current assets	1,866,162	0	0	0	9.00
10.00	Due from other funds	142,953	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,834,507	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	410,028	0	0	0	12.00
13.00	Land improvements	1,922,999	0	0	0	13.00
14.00	Accumulated depreciation	-1,382,122	0	0	0	14.00
15.00	Buildings	38,917,525	0	0	0	15.00
16.00	Accumulated depreciation	-19,073,315	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	23,773,570	0	0	0	23.00
24.00	Accumulated depreciation	-18,741,423	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,827,262	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	47,509,757	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	7,263,057	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	54,772,814	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	91,434,583	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,187,336	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,235,699	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,866,162	0	0	0	40.00
41.00	Deferred income	86,043	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	124,675	0	0	0	43.00
44.00	Other current liabilities	1,899,187	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,399,102	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,358,910	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,923,733	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,282,643	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,681,745	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	70,752,838				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)	70,752,838	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	91,434,583	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/16/2018 10:51 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		55,700,646		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,646,735				2.00
3.00	Total (sum of line 1 and line 2)		71,347,381		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)		71,347,381		0		11.00
12.00	TEMP RESTRICTED	72,530		0		0	12.00
13.00	UNRESTRICTED	522,013		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)		594,543		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		70,752,838		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	TEMP RESTRICTED		0		12.00
13.00	UNRESTRICTED		0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/16/2018 10:51 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,454,676		4,454,676	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	157,374		157,374	5.00
6.00	Swing bed - NF	9,404		9,404	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,621,454		4,621,454	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,621,454		4,621,454	17.00
18.00	Ancillary services	17,830,849	82,337,998	100,168,847	18.00
19.00	Outpatient services	1,602,052	13,152,369	14,754,421	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	55,386	239,765	295,151	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,109,741	95,730,132	119,839,873	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,614,299		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)		35,614,299		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1350 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/16/2018 10:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	119,839,873	1.00
2.00	Less contractual allowances and discounts on patients' accounts	71,559,237	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,280,636	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,614,299	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,666,337	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,859,865	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	9,161	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	469	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	45,512	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	170,692	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	738,113	24.00
24.01	GRANTS	51,103	24.01
24.02	AFFILIATE COSTS	118,983	24.02
25.00	Total other income (sum of lines 6-24)	2,993,898	25.00
26.00	Total (line 5 plus line 25)	15,660,235	26.00
27.00	NON-OPERATING EXPENSES	20,036	27.00
27.01	LOSS ON DISPOSALS	-6,536	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	13,500	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,646,735	29.00