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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-2013	Period: From 09/01/2017 To 08/31/2018	Worksheet S Parts I-III Date/Time Prepared: 1/22/2019 11:31 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/22/2019 Time: 11:31 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 Kindred Hospital Peoria (14-2013) for the cost reporting period beginning 09/01/2017 and ending 08/31/2018 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)

SR VICE PRESIDENT OF REIMBURSEMENT
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	-94,792	0	0	45,469	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	-94,792	0	0	45,469	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 1/14/2019 1:33 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 500 West Romeo B Garrett Ave.	PO Box:			1.00
2.00	City: Peoria	State: IL	Zip Code: 61605	County: Peoria	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	Kindred Hospital Peoria	142013	37900	2	05/01/2010	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2017	08/31/2018	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	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	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 1/14/2019 1:33 pm

		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	
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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? 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), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/14/2019 1:33 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 1/14/2019 1:33 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 1/14/2019 1:33 pm

				1.00	
	Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			Y	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
	TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
	Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
	Rural Providers				
105.00	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/14/2019 1:33 pm

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	7,357	0	31,784	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	189003	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/14/2019 1:33 pm

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: KINDRED HEALTHCARE OPERATING LLC		Contractor's Name: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 05901	141.00
142.00	Street: 680 SOUTH FOURTH AVENUE		PO Box:		142.00
143.00	City: LOUISVILLE		State: KY	Zip Code: 40202	143.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 1/14/2019 1:33 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2019	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	11/30/2018	Y	11/30/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 1/14/2019 1:33 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2018	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-2013	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part II Date/Time Prepared: 1/14/2019 1:33 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 1/14/2019 1:33 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	50	18,250	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		50	18,250	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		50	18,250	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		50				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: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 1/14/2019 1:33 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,259	10	7,275			1.00
2.00	HMO and other (see instructions)	462	1,535				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,259	10	7,275			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,259	10	7,275	0.00	76.60	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	76.60	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	22					33.00
33.01	LTCH site neutral days and discharges	751					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 1/14/2019 1:33 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	131	1	270	1.00
2.00	HMO and other (see instructions)			20	65		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	131	1	270	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			29			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 1/14/2019 1:33 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	5,448,980	0	5,448,980	159,547.53	34.15	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	100,220	100,220	2,297.00	43.63	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,166,197	0	1,166,197	18,735.00	62.25	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		57,674	0	57,674	296.00	194.84	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		769,809	0	769,809	16,375.43	47.01	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		728,665	0	728,665			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		13,653	0	13,653			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	51,294	0	51,294	798.36	64.25	26.00
27.00	Administrative & General	5.00	1,360,246	0	1,360,246	24,805.37	54.84	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part II | Date/Time Prepared: 1/14/2019 1:33 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		3,037	0	3,037	106.00	28.65	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	95,610	0	95,610	8,748.00	10.93	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	213,669	0	213,669	12,557.00	17.02	34.00
35.00	Dietary under contract (see instructions)		33,662	0	33,662	540.00	62.34	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	574,156	0	574,156	13,714.00	41.87	38.00
39.00	Central Services and Supply	14.00	39,146	0	39,146	2,542.00	15.40	39.00
40.00	Pharmacy	15.00	311,175	0	311,175	7,088.00	43.90	40.00
41.00	Medical Records & Medical Records Library	16.00	164,957	0	164,957	5,864.00	28.13	41.00
42.00	Social Service	17.00	266,061	-100,220	165,841	3,801.00	43.63	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 1/14/2019 1:33 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		5,485,679	0	5,485,679	160,193.53	34.24	1.00
2.00	Excluded area salaries (see instructions)		0	100,220	100,220	2,297.00	43.63	2.00
3.00	Subtotal salaries (line 1 minus line 2)		5,485,679	-100,220	5,385,459	157,896.53	34.11	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,993,680	0	1,993,680	35,406.43	56.31	4.00
5.00	Subtotal wage-related costs (see inst.)		728,665	0	728,665	0.00	13.53	5.00
6.00	Total (sum of lines 3 thru 5)		8,208,024	-100,220	8,107,804	193,302.96	41.94	6.00
7.00	Total overhead cost (see instructions)		3,113,013	-100,220	3,012,793	80,563.73	37.40	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 1/14/2019 1:33 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,936	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	286,054	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	2,941	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	3,121	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	13,364	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	-5,095	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	355,513	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	67,311	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	2,521	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	728,666	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 1/14/2019 1:33 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,166,197	728,665	1.00
2.00	Hospital	1,166,197	728,665	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,424,820	1,424,820	85,333	1,510,153	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		244,354	244,354	456,065	700,419	2.00
3.00	00300	OTHER CAP REL COSTS		548,031	548,031	-548,031	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	51,294	795,669	846,963	0	846,963	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,360,246	1,182,202	2,542,448	32,645	2,575,093	5.00
7.00	00700	OPERATION OF PLANT	0	626,130	626,130	-70,253	555,877	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,280	56,280	0	56,280	8.00
9.00	00900	HOUSEKEEPING	95,610	10,653	106,263	280	106,543	9.00
10.00	01000	DIETARY	213,669	166,123	379,792	537	380,329	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	574,156	3,384	577,540	2,553	580,093	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,146	3,340	42,486	21,894	64,380	14.00
15.00	01500	PHARMACY	311,175	23,508	334,683	3,239	337,922	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	164,957	12,143	177,100	111	177,211	16.00
17.00	01700	SOCIAL SERVICE	266,061	18,854	284,915	-107,322	177,593	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,715,929	1,406,720	3,122,649	242,748	3,365,397	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	68,317	83,019	151,336	189	151,525	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,605	4,383	98,988	56,442	155,430	54.00
60.00	06000	LABORATORY	0	186,897	186,897	1,441	188,338	60.00
65.00	06500	RESPIRATORY THERAPY	493,815	133,170	626,985	58,962	685,947	65.00
66.00	06600	PHYSICAL THERAPY	0	337,266	337,266	786	338,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	448,517	448,517	-344,941	103,576	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	499,417	499,417	0	499,417	73.00
74.00	07400	RENAL DIALYSIS	0	188,253	188,253	0	188,253	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,448,980	8,403,133	13,852,113	-107,322	13,744,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	107,322	107,322	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	5,448,980	8,403,133	13,852,113	0	13,852,113	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-4,712	1,505,441		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4,774	695,645		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	28,796	875,759		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	858,451	3,433,544		5.00
7.00	00700	OPERATION OF PLANT	-520	555,357		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,280		8.00
9.00	00900	HOUSEKEEPING	0	106,543		9.00
10.00	01000	DIETARY	-14,348	365,981		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	580,093		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	64,380		14.00
15.00	01500	PHARMACY	0	337,922		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	177,211		16.00
17.00	01700	SOCIAL SERVICE	0	177,593		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-292,777	3,072,620		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	151,525		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-70	155,360		54.00
60.00	06000	LABORATORY	0	188,338		60.00
65.00	06500	RESPIRATORY THERAPY	0	685,947		65.00
66.00	06600	PHYSICAL THERAPY	0	338,052		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	103,576		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	499,417		73.00
74.00	07400	RENAL DIALYSIS	0	188,253		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	570,046	14,314,837		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	107,322		194.00
194.01	07951	IDLE SPACE	0	0		194.01
194.02	07952	REGIONAL OFFICE	0	0		194.02
194.03	07953	DISTRICT OFFICE	0	0		194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0		194.04
194.05	07955	REG NURSG OFFICE	0	0		194.05
194.06	07956	CONTACT CENTER	0	0		194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0		194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0		194.08
194.09	07958	VISITOR MEALS	0	0		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	570,046	14,422,159		200.00

RECLASSIFICATIONS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/14/2019 1:33 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS NON ALLOWABLE CASE MANAGER					
1.00	NONALLOWABLE CLINICAL LIAISON	194.00	100,220	7,102		1.00
	TOTALS		100,220	7,102		
	B - RECLASS OXYGEN					
1.00	RESPIRATORY THERAPY	65.00	0	25,769		1.00
	TOTALS		0	25,769		
	C - RECLASS NON-CHARGEABLE MED SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	32,645		1.00
2.00	HOUSEKEEPING	9.00	0	280		2.00
3.00	DIETARY	10.00	0	537		3.00
4.00	NURSING ADMINISTRATION	13.00	0	2,553		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	21,894		5.00
6.00	PHARMACY	15.00	0	3,239		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	111		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	238,668		8.00
9.00	OPERATING ROOM	50.00	0	189		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,163		10.00
11.00	LABORATORY	60.00	0	121		11.00
12.00	RESPIRATORY THERAPY	65.00	0	15,986		12.00
13.00	PHYSICAL THERAPY	66.00	0	786		13.00
	TOTALS		0	319,172		
	D - RECLASS JLL EQUIPMENT SERV CONTRACTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	54,279		1.00
2.00	LABORATORY	60.00	0	1,320		2.00
3.00	RESPIRATORY THERAPY	65.00	0	14,654		3.00
	TOTALS		0	70,253		
	E - RECLASS OXYGEN					
1.00	RESPIRATORY THERAPY	65.00	0	6,633		1.00
	TOTALS		0	6,633		
	F - RECLASS RT EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	0	4,080		1.00
	TOTALS		0	4,080		
500.00	Grand Total: Increases		100,220	433,009		500.00

RECLASSIFICATIONS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/14/2019 1:33 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	SOCIAL SERVICE	17.00	100,220	7,102	0		1.00
	TOTALS		100,220	7,102			
	B - RECLASS OXYGEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	25,769	0		1.00
	TOTALS		0	25,769			
	C - RECLASS NON-CHARGEABLE MED SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	319,172	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	TOTALS		0	319,172			
	D - RECLASS JLL EQUIPMENT SERV CONTRACTS						
1.00	OPERATION OF PLANT	7.00	0	70,253	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	70,253			
	E - RECLASS OXYGEN						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,633	10		1.00
	TOTALS		0	6,633			
	F - RECLASS RT EXPENSE						
1.00	RESPIRATORY THERAPY	65.00	0	4,080	0		1.00
	TOTALS		0	4,080			
500.00	Grand Total: Decreases		100,220	433,009			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 1/14/2019 1:33 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	197,980	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	910,188	236,446	0	236,446	73,134	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,108,168	236,446	0	236,446	73,134	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,108,168	236,446	0	236,446	73,134	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	197,980	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	1,073,500	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,271,480	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	1,271,480	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 1/14/2019 1:33 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	16,633	1,408,187	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	83,013	161,341	0	0	0	2.00
3.00	Total (sum of lines 1-2)	99,646	1,569,528	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,424,820	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	244,354	2.00
3.00	Total (sum of lines 1-2)	0	1,669,174	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-7 Part III | Date/Time Prepared: 1/14/2019 1:33 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	197,980	0	197,980	0.155708	4,208	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,073,500	0	1,073,500	0.844292	22,816	2.00
3.00	Total (sum of lines 1-2)	1,271,480	0	1,271,480	1.000000	27,024	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	81,125	0	85,333	22,190	1,408,187	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	439,882	0	462,698	78,239	154,708	2.00
3.00	Total (sum of lines 1-2)	521,007	0	548,031	100,429	1,562,895	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	-6,061	81,125	0	1,505,441	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,816	439,882	0	695,645	2.00
3.00	Total (sum of lines 1-2)	0	16,755	521,007	0	2,201,086	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/14/2019 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-9,909	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,035	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,487	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-520	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	-292,777			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	1,192,883			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-14,348	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/14/2019 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-13,261	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	RADIOLOGY COPY FEES	B	-70	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	A	-159,732	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	A	-2,829	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	A	-14	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	A	-967	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER OPERATING - MARKETING	A	-48,320	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER OPERATING - INTEREST	A	-452	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	CHARITABLE CONTRIBUTIONS	A	-1,000	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	OTHER OPERATING - PENALTIES OTHER	A	-491	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
33.29	CABLE TV AND SATELLITE	A	-3,805	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	VENDING MACHINE	A	298	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.32
33.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.33
33.34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.34
33.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.35
33.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	A	-37,408	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.38
33.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.39

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/14/2019 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.40	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.40
33.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.41
33.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.42
33.43	DISTRICT OFFICE SALES AND MARKETING	A	-66,159	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	DISTRICT OFC SALES AND MKT BENEFITS	A	-7,978	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	BUSINESS INTERRUPTIONS INS PREMIUM	A	-10,269	CAP REL COSTS-BLDG & FIXT	1.00	12	33.45
34.00	MEDICARE VS BOOK BLDG	A	5,557	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	A	-38,369	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.02
34.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.03
34.04	ASSET ADD-ON MOV EQUIP	A	33,595	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.04
34.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.05
34.06	MSA MGMT FEE REV ADD-BACK	A	408,419	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07	MSA MGMT FEE EXP OFFSET	A	-352,225	ADMINISTRATIVE & GENERAL	5.00	0	34.07
34.08	NON ALLOWABLE LOBBYING FEES	A	-5,281	ADMINISTRATIVE & GENERAL	5.00	0	34.08
34.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.09
34.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.10
34.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.11
34.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.12
34.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.13
34.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.14
34.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.15
34.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.16
34.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.17
34.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.18
34.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.19
34.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.20
34.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.21
34.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.22
34.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.23
34.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.24
34.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.25
34.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.26
34.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.27
34.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.28
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
35.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.01
35.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/14/2019 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.03
35.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.04
35.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.05
35.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.06
35.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.07
35.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.08
35.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.09
35.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.10
35.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.11
35.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.12
35.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.13
35.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.14
35.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.15
35.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.16
35.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.17
35.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.18
35.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.19
35.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.20
35.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.21
35.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.22
35.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.23
35.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.24
35.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		570,046				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-2013	Period: From 09/01/2017 To 08/31/2018	Worksheet A-8-1 Date/Time Prepared: 1/14/2019 1:33 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COSTS	1,193,173	0	1.00
2.00	0.00			0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	0	-36,774	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	0	37,064	4.00
4.22	60.00	LABORATORY	Hospital Related services	178,137	178,137	4.22
5.00	0		0	1,371,310	178,427	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00			0.00		0.00	6.00
7.00	B	KHOLLC	100.00	Cornerstone	100.00	7.00
8.00	B	KHOLLC	100.00	Cornerstone	100.00	8.00
9.00			0.00		0.00	9.00
10.00	B		49.00	Methodist M.C.	49.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-2013	Period: From 09/01/2017 To 08/31/2018	Worksheet A-8-1 Date/Time Prepared: 1/14/2019 1:33 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,193,173	0		1.00
2.00	0	0		2.00
3.00	36,774	0		3.00
4.00	-37,064	0		4.00
4.22	0	0		4.22
5.00	1,192,883			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			6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00			9.00
10.00	Hospital/JV		10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 1/14/2019 1:33 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	42,000	0	42,000	211,500	210	1.00
2.00	30.00	DR. B	3,094	0	3,094	211,500	19	2.00
3.00	30.00	DR. C	260,384	260,384	0	211,500	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	30.00	DR. E	10,584	10,584	0	211,500	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			316,062	270,968	45,094		229	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	21,353	1,068	0	0	0	1.00
2.00	30.00	DR. B	1,932	97	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	30.00	DR. E	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			23,285	1,165	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. A	0	21,353	20,647	20,647		1.00
2.00	30.00	DR. B	0	1,932	1,162	1,162		2.00
3.00	30.00	DR. C	0	0	0	260,384		3.00
4.00	0.00		0	0	0	0		4.00
5.00	30.00	DR. E	0	0	0	10,584		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	23,285	21,809	292,777		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,505,441	1,505,441				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	695,645		695,645			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	875,759	7,695	3,556	887,010		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,433,544	61,559	28,446	223,532	3,747,081	5.00
7.00	00700	OPERATION OF PLANT	555,357	173,669	80,250	0	809,276	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,280	0	0	0	56,280	8.00
9.00	00900	HOUSEKEEPING	106,543	23,833	11,013	15,712	157,101	9.00
10.00	01000	DIETARY	365,981	86,781	40,100	35,113	527,975	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	580,093	13,039	6,025	94,352	693,509	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64,380	40,077	18,519	6,433	129,409	14.00
15.00	01500	PHARMACY	337,922	21,241	9,815	51,136	420,114	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	177,211	21,775	10,062	27,108	236,156	16.00
17.00	01700	SOCIAL SERVICE	177,593	15,764	7,284	27,253	227,894	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,072,620	718,054	331,804	281,978	4,404,456	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	151,525	0	0	11,227	162,752	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	155,360	26,344	12,173	15,547	209,424	54.00
60.00	06000	LABORATORY	188,338	6,519	3,012	0	197,869	60.00
65.00	06500	RESPIRATORY THERAPY	685,947	12,958	5,988	81,150	786,043	65.00
66.00	06600	PHYSICAL THERAPY	338,052	276,133	127,598	0	741,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,576	0	0	0	103,576	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	499,417	0	0	0	499,417	73.00
74.00	07400	RENAL DIALYSIS	188,253	0	0	0	188,253	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,314,837	1,505,441	695,645	870,541	14,298,368	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	107,322	0	0	16,469	123,791	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,422,159	1,505,441	695,645	887,010	14,422,159	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,747,081					5.00
7.00	00700	OPERATION OF PLANT	284,066	1,093,342				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,755	0	76,035			8.00
9.00	00900	HOUSEKEEPING	55,144	20,639	0	232,884		9.00
10.00	01000	DIETARY	185,326	75,152	0	16,316	804,769	10.00
11.00	01100	CAFETERIA	0	0	0	0	255,196	11.00
13.00	01300	NURSING ADMINISTRATION	243,430	11,291	0	2,451	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,424	34,707	0	7,535	0	14.00
15.00	01500	PHARMACY	147,465	18,395	0	3,994	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	82,894	18,858	0	4,094	0	16.00
17.00	01700	SOCIAL SERVICE	79,994	13,651	0	2,964	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,546,017	621,835	76,035	134,999	521,614	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,128	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,510	22,814	0	4,953	0	54.00
60.00	06000	LABORATORY	69,454	5,646	0	1,226	0	60.00
65.00	06500	RESPIRATORY THERAPY	275,911	11,222	0	2,436	0	65.00
66.00	06600	PHYSICAL THERAPY	260,375	239,132	0	51,916	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,356	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	175,301	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	66,079	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,703,629	1,093,342	76,035	232,884	776,810	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	43,452	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	27,959	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,747,081	1,093,342	76,035	232,884	804,769	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	255,196					11.00
13.00	01300	NURSING ADMINISTRATION	32,479	983,160				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,640	0	221,715			14.00
15.00	01500	PHARMACY	13,920	0	5,192	609,080		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,920	0	206	0	356,128	16.00
17.00	01700	SOCIAL SERVICE	13,920	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	129,918	949,258	142,817	2,692	182,712	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,640	33,902	111	0	1,076	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,640	0	1,266	0	8,894	54.00
60.00	06000	LABORATORY	0	0	71	0	19,892	60.00
65.00	06500	RESPIRATORY THERAPY	37,119	0	11,009	0	68,891	65.00
66.00	06600	PHYSICAL THERAPY	0	0	460	0	11,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	60,583	0	3,302	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	606,388	54,681	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	5,294	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	255,196	983,160	221,715	609,080	356,128	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	255,196	983,160	221,715	609,080	356,128	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	338,423					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	338,423	9,050,776	0	9,050,776		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	259,609	0	259,609		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	325,501	0	325,501		54.00
60.00	06000	LABORATORY	0	294,158	0	294,158		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,192,631	0	1,192,631		65.00
66.00	06600	PHYSICAL THERAPY	0	1,305,052	0	1,305,052		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	203,817	0	203,817		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,335,787	0	1,335,787		73.00
74.00	07400	RENAL DIALYSIS	0	259,626	0	259,626		74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	338,423	14,226,957	0	14,226,957		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	167,243	0	167,243		194.00
194.01	07951	IDLE SPACE	0	0	0	0		194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0		194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0		194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0		194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0		194.05
194.06	07956	CONTACT CENTER	0	0	0	0		194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0		194.08
194.09	07958	VISITOR MEALS	0	27,959	0	27,959		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194.11
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	338,423	14,422,159	0	14,422,159		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,695	3,556	11,251	11,251	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	108,935	61,559	28,446	198,940	2,835	5.00
7.00	00700	OPERATION OF PLANT	0	173,669	80,250	253,919	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	23,833	11,013	34,846	199	9.00
10.00	01000	DIETARY	0	86,781	40,100	126,881	445	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,039	6,025	19,064	1,197	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	40,077	18,519	58,596	82	14.00
15.00	01500	PHARMACY	0	21,241	9,815	31,056	648	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,775	10,062	31,837	344	16.00
17.00	01700	SOCIAL SERVICE	0	15,764	7,284	23,048	346	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	718,054	331,804	1,049,858	3,578	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	142	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,344	12,173	38,517	197	54.00
60.00	06000	LABORATORY	0	6,519	3,012	9,531	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,958	5,988	18,946	1,029	65.00
66.00	06600	PHYSICAL THERAPY	0	276,133	127,598	403,731	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,935	1,505,441	695,645	2,310,021	11,042	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	209	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	108,935	1,505,441	695,645	2,310,021	11,251	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	201,775					5.00
7.00	00700	OPERATION OF PLANT	15,297	269,216				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,064	0	1,064			8.00
9.00	00900	HOUSEKEEPING	2,970	5,082	0	43,097		9.00
10.00	01000	DIETARY	9,980	18,505	0	3,019	158,830	10.00
11.00	01100	CAFETERIA	0	0	0	0	50,366	11.00
13.00	01300	NURSING ADMINISTRATION	13,109	2,780	0	454	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,446	8,546	0	1,394	0	14.00
15.00	01500	PHARMACY	7,941	4,529	0	739	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,464	4,643	0	758	0	16.00
17.00	01700	SOCIAL SERVICE	4,308	3,361	0	548	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,246	153,117	1,064	24,983	102,946	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,076	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,959	5,618	0	917	0	54.00
60.00	06000	LABORATORY	3,740	1,390	0	227	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,858	2,763	0	451	0	65.00
66.00	06600	PHYSICAL THERAPY	14,021	58,882	0	9,607	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,958	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,440	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,558	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	199,435	269,216	1,064	43,097	153,312	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	2,340	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	5,518	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	201,775	269,216	1,064	43,097	158,830	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	50,366					11.00
13.00	01300	NURSING ADMINISTRATION	6,410	43,014				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	916	0	71,980			14.00
15.00	01500	PHARMACY	2,747	0	1,686	49,346		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,747	0	67	0	44,860	16.00
17.00	01700	SOCIAL SERVICE	2,747	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,641	41,531	46,366	218	23,015	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	916	1,483	36	0	136	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	916	0	411	0	1,120	54.00
60.00	06000	LABORATORY	0	0	23	0	2,506	60.00
65.00	06500	RESPIRATORY THERAPY	7,326	0	3,574	0	8,678	65.00
66.00	06600	PHYSICAL THERAPY	0	0	149	0	1,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	19,668	0	416	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	49,128	6,888	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	667	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,366	43,014	71,980	49,346	44,860	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	50,366	43,014	71,980	49,346	44,860	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	34,358					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,358	1,589,921	0	1,589,921		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,789	0	5,789		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,655	0	51,655		54.00
60.00	06000	LABORATORY	0	17,417	0	17,417		60.00
65.00	06500	RESPIRATORY THERAPY	0	57,625	0	57,625		65.00
66.00	06600	PHYSICAL THERAPY	0	487,824	0	487,824		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,042	0	22,042		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	65,456	0	65,456		73.00
74.00	07400	RENAL DIALYSIS	0	4,225	0	4,225		74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,358	2,301,954	0	2,301,954		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	2,549	0	2,549		194.00
194.01	07951	IDLE SPACE	0	0	0	0		194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0		194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0		194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0		194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0		194.05
194.06	07956	CONTACT CENTER	0	0	0	0		194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0		194.08
194.09	07958	VISITOR MEALS	0	5,518	0	5,518		194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194.11
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	34,358	2,310,021	0	2,310,021		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET #1)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET #2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	56,345					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		56,345				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	288	288	5,397,686			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,304	2,304	1,360,246	-3,747,081	10,675,078	5.00
7.00	00700	OPERATION OF PLANT	6,500	6,500	0	0	809,276	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	56,280	8.00
9.00	00900	HOUSEKEEPING	892	892	95,610	0	157,101	9.00
10.00	01000	DIETARY	3,248	3,248	213,669	0	527,975	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	488	488	574,156	0	693,509	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,500	1,500	39,146	0	129,409	14.00
15.00	01500	PHARMACY	795	795	311,175	0	420,114	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	815	815	164,957	0	236,156	16.00
17.00	01700	SOCIAL SERVICE	590	590	165,841	0	227,894	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,875	26,875	1,715,929	0	4,404,456	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	68,317	0	162,752	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986	986	94,605	0	209,424	54.00
60.00	06000	LABORATORY	244	244	0	0	197,869	60.00
65.00	06500	RESPIRATORY THERAPY	485	485	493,815	0	786,043	65.00
66.00	06600	PHYSICAL THERAPY	10,335	10,335	0	0	741,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	103,576	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	499,417	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	188,253	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,345	56,345	5,297,466	-3,747,081	10,551,287	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	100,220	0	123,791	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,505,441	695,645	887,010		3,747,081	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.718271	12.346171	0.164332		0.351012	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,251		201,775	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002084		0.018902	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: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	47,253					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,275				8.00
9.00	00900	HOUSEKEEPING	892	0	46,361			9.00
10.00	01000	DIETARY	3,248	0	3,248	16,925		10.00
11.00	01100	CAFETERIA	0	0	0	5,367	55	11.00
13.00	01300	NURSING ADMINISTRATION	488	0	488	0	7	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,500	0	1,500	0	1	14.00
15.00	01500	PHARMACY	795	0	795	0	3	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	815	0	815	0	3	16.00
17.00	01700	SOCIAL SERVICE	590	0	590	0	3	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,875	7,275	26,875	10,970	28	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	1	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986	0	986	0	1	54.00
60.00	06000	LABORATORY	244	0	244	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	485	0	485	0	8	65.00
66.00	06600	PHYSICAL THERAPY	10,335	0	10,335	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,253	7,275	46,361	16,337	55	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	588	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,093,342	76,035	232,884	804,769	255,196	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.138044	10.451546	5.023274	47.549129	4,639.927273	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	269,216	1,064	43,097	158,830	50,366	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.697331	0.146254	0.929596	9.384343	915.745455	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: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/14/2019 1:33 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	29					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	379,055				14.00
15.00	01500	PHARMACY	0	8,877	501,634			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	352	0	49,241,346		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	7,275	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28	244,167	2,217	25,262,247	7,275	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1	189	0	148,795	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,165	0	1,229,789	0	54.00
60.00	06000	LABORATORY	0	121	0	2,750,590	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,821	0	9,525,895	0	65.00
66.00	06600	PHYSICAL THERAPY	0	787	0	1,574,410	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	103,576	0	456,585	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	499,417	7,561,047	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	731,988	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29	379,055	501,634	49,241,346	7,275	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	983,160	221,715	609,080	356,128	338,423	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33,902.068966	0.584915	1.214192	0.007232	46.518625	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,014	71,980	49,346	44,860	34,358	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,483.241379	0.189893	0.098371	0.000911	4.722749	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: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,050,776		9,050,776	21,809	9,072,585	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	259,609		259,609	0	259,609	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	325,501		325,501	0	325,501	54.00
60.00	06000	LABORATORY	294,158		294,158	0	294,158	60.00
65.00	06500	RESPIRATORY THERAPY	1,192,631	0	1,192,631	0	1,192,631	65.00
66.00	06600	PHYSICAL THERAPY	1,305,052	0	1,305,052	0	1,305,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	203,817		203,817	0	203,817	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,335,787		1,335,787	0	1,335,787	73.00
74.00	07400	RENAL DIALYSIS	259,626		259,626	0	259,626	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00		Subtotal (see instructions)	14,226,957	0	14,226,957	21,809	14,248,766	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	14,226,957	0	14,226,957	21,809	14,248,766	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,262,247		25,262,247			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	148,795	0	148,795	1.744743	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,208,752	21,037	1,229,789	0.264680	0.000000	54.00
60.00	06000	LABORATORY	2,676,571	74,019	2,750,590	0.106944	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,505,612	20,283	9,525,895	0.125199	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,546,963	27,447	1,574,410	0.828915	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	453,419	3,166	456,585	0.446394	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,561,047	0	7,561,047	0.176667	0.000000	73.00
74.00	07400	RENAL DIALYSIS	698,616	33,372	731,988	0.354686	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	49,062,022	179,324	49,241,346			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	49,062,022	179,324	49,241,346			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	1.744743	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.264680	54.00
60.00	06000	LABORATORY	0.106944	60.00
65.00	06500	RESPIRATORY THERAPY	0.125199	65.00
66.00	06600	PHYSICAL THERAPY	0.828915	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446394	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176667	73.00
74.00	07400	RENAL DIALYSIS	0.354686	74.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/14/2019 1:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,050,776		9,050,776	21,809	9,072,585	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	259,609		259,609	0	259,609	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	325,501		325,501	0	325,501	54.00
60.00	06000	LABORATORY	294,158		294,158	0	294,158	60.00
65.00	06500	RESPIRATORY THERAPY	1,192,631	0	1,192,631	0	1,192,631	65.00
66.00	06600	PHYSICAL THERAPY	1,305,052	0	1,305,052	0	1,305,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	203,817		203,817	0	203,817	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,335,787		1,335,787	0	1,335,787	73.00
74.00	07400	RENAL DIALYSIS	259,626		259,626	0	259,626	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00		Subtotal (see instructions)	14,226,957	0	14,226,957	21,809	14,248,766	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	14,226,957	0	14,226,957	21,809	14,248,766	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/14/2019 1:33 pm

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	25,262,247		25,262,247			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	148,795	0	148,795	1.744743	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,208,752	21,037	1,229,789	0.264680	0.000000	54.00
60.00	06000	LABORATORY	2,676,571	74,019	2,750,590	0.106944	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,505,612	20,283	9,525,895	0.125199	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,546,963	27,447	1,574,410	0.828915	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	453,419	3,166	456,585	0.446394	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,561,047	0	7,561,047	0.176667	0.000000	73.00
74.00	07400	RENAL DIALYSIS	698,616	33,372	731,988	0.354686	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	49,062,022	179,324	49,241,346			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	49,062,022	179,324	49,241,346			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/14/2019 1:33 pm

Title XIX | Hospital | Cost

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part I Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,589,921	0	1,589,921	7,275	218.55	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,589,921		1,589,921	7,275		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	3,259	712,254	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	3,259	712,254	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part II Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,789	148,795	0.038906	142,333	5,538	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,655	1,229,789	0.042003	547,293	22,988	54.00
60.00	06000	LABORATORY	17,417	2,750,590	0.006332	1,400,408	8,867	60.00
65.00	06500	RESPIRATORY THERAPY	57,625	9,525,895	0.006049	4,169,081	25,219	65.00
66.00	06600	PHYSICAL THERAPY	487,824	1,574,410	0.309846	675,529	209,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,042	456,585	0.048276	196,787	9,500	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,456	7,561,047	0.008657	3,451,588	29,880	73.00
74.00	07400	RENAL DIALYSIS	4,225	731,988	0.005772	414,732	2,394	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	712,033	23,979,099		10,997,751	313,696	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part III Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,275	0.00	3,259	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	7,275		3,259	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	148,795	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,229,789	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	2,750,590	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,525,895	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,574,410	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	456,585	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,561,047	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	731,988	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	23,979,099		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	142,333	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	547,293	0	9,690	0	54.00
60.00	06000	LABORATORY	0.000000	1,400,408	0	2,242	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,169,081	0	12,740	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	675,529	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	196,787	0	750	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,451,588	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	414,732	0	33,372	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		10,997,751	0	58,794	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.744743	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.264680	9,690	0	0	2,565	54.00
60.00	06000	LABORATORY	0.106944	2,242	0	0	240	60.00
65.00	06500	RESPIRATORY THERAPY	0.125199	12,740	0	0	1,595	65.00
66.00	06600	PHYSICAL THERAPY	0.828915	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446394	750	0	0	335	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176667	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.354686	33,372	0	0	11,837	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		58,794	0	0	16,572	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		58,794	0	0	16,572	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	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: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,275	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,275	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)	7,275	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,259	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,072,585	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,072,585	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)	9,072,585	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)	1,247.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,064,266	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)	4,064,266	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,469,606	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,533,872	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)	712,254	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	313,696	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,025,950	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,507,922	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,589,921	9,072,585	0.175245	0	0	90.00
91.00	Nursing School cost	0	9,072,585	0.000000	0	0	91.00
92.00	Allied health cost	0	9,072,585	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,072,585	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-2013	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/14/2019 1:33 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,275	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,275	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)	7,275	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	10	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,050,776	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,050,776	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)	9,050,776	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)	1,244.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	12,441	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)	12,441	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/14/2019 1:33 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,603	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	15,044	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/14/2019 1:33 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,589,921	9,050,776	0.175667	0	0	90.00
91.00	Nursing School cost	0	9,050,776	0.000000	0	0	91.00
92.00	Allied health cost	0	9,050,776	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,050,776	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-2 | Date/Time Prepared: 1/14/2019 1:33 pm

	Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered	0.00	0				1.00
	Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	0.00	0	7,275	0.00	0	2.00
3.00	INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)	0.00	0				9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)	0.00	0				20.00

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

	Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
	Hospital Inpatient Routine Services:						
29.00	ADULTS & PEDIATRICS	0	0	0	7,275	0.00	29.00
30.00	Swing Bed - SNF		0	0	0	0.00	30.00
31.00	Swing Bed - NF		0				31.00
32.00	INTENSIVE CARE UNIT	0		0	0	0.00	32.00
33.00	CORONARY CARE UNIT						33.00
34.00	BURN INTENSIVE CARE UNIT						34.00
35.00	SURGICAL INTENSIVE CARE UNIT						35.00
36.00	OTHER SPECIAL CARE (SPECIFY)						36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)	0		0			37.00
38.00	SUBPROVIDER - IPF						38.00
39.00	SUBPROVIDER - IRF						39.00
40.00	SUBPROVIDER						40.00
41.00	SKILLED NURSING FACILITY	0		0	0	0.00	41.00
42.00	Total (sum of lines 37 through 41)	0		0			42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-2 | Date/Time Prepared: 1/14/2019 1:33 pm

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

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-2 | Date/Time Prepared: 1/14/2019 1:33 pm

	Cost Center Description	Health Care Program Inpatient Days: Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Health Care Program Inpatient Days: Title XIX	Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
		6.00	7.00	8.00	9.00	10.00	
	PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered						1.00
	Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	3,259	10	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)						20.00

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

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

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-2 | Date/Time Prepared: 1/14/2019 1:33 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		11,320,541		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.744743	142,333	248,335	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.264680	547,293	144,858	54.00
60.00	06000	LABORATORY	0.106944	1,400,408	149,765	60.00
65.00	06500	RESPIRATORY THERAPY	0.125199	4,169,081	521,965	65.00
66.00	06600	PHYSICAL THERAPY	0.828915	675,529	559,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446394	196,787	87,845	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176667	3,451,588	609,782	73.00
74.00	07400	RENAL DIALYSIS	0.354686	414,732	147,100	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,997,751	2,469,606	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)		10,997,751		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/14/2019 1:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		34,160		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.744743	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.264680	0	0	54.00
60.00	06000	LABORATORY	0.106944	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.125199	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.828915	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446394	1,084	484	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176667	11,995	2,119	73.00
74.00	07400	RENAL DIALYSIS	0.354686	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,079	2,603	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		13,079		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-2013	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part B Date/Time Prepared: 1/14/2019 1:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	16,572	2.00
3.00	OPPS payments	17,778	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)	0	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)	0	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)	17,778	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,556	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	14,222	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	14,222	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	14,222	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	14,222	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)	14,222	40.00
40.01	Sequestration adjustment (see instructions)	284	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	13,938	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	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: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 1/14/2019 1:33 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,234,547		13,938	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/27/2018	1,654,467		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-1,654,467		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)		5,580,080		13,938	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		94,792		0	6.02
7.00	Total Medicare program liability (see instructions)		5,485,288		13,938	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-2013	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part IV Date/Time Prepared: 1/14/2019 1:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	5,259,457	1.00
1.01	Full standard payment amount	4,531,715	1.01
1.02	Short stay outlier standard payment amount	582,288	1.02
1.03	Site neutral payment amount - Cost	6,341	1.03
1.04	Site neutral payment amount - IPPS comparable	139,113	1.04
2.00	Outlier Payments	563,483	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	5,822,940	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	5,822,940	7.00
8.00	Primary payer payments	0	8.00
9.00	Subtotal (line 7 less line 8).	5,822,940	9.00
10.00	Deductibles	13,232	10.00
11.00	Subtotal (line 9 minus line 10)	5,809,708	11.00
12.00	Coinsurance	316,301	12.00
13.00	Subtotal (line 11 minus line 12)	5,493,407	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	159,732	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	103,826	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	93,122	16.00
17.00	Subtotal (sum of lines 13 and 15)	5,597,233	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.99	Demonstration payment adjustment amount before sequestration	0	21.99
22.00	Total amount payable to the provider (see instructions)	5,597,233	22.00
22.01	Sequestration adjustment (see instructions)	111,945	22.01
22.02	Demonstration payment adjustment amount after sequestration	0	22.02
23.00	Interim payments	5,580,080	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	-94,792	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	5,771	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)	563,483	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-2013	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 1/14/2019 1:33 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	15,044		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	15,044	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	15,044	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	34,160		8.00
9.00	Ancillary service charges	13,079	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	47,239	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	47,239	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	32,195	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	15,044	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	15,044	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	15,044	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	15,044	0	36.00
37.00	OTHER ADJUSTMENTS	0	0	37.00
37.01	OTHER ADJUSTMENTS	0	0	37.01
38.00	Subtotal (line 36 ± line 37)	15,044	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	15,044	0	40.00
41.00	Interim payments	-30,425	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	45,469	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet G | Date/Time Prepared: 1/14/2019 1:33 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	783,530	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	3,348,313	0	0	0	4.00
5.00	Other receivable	668	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-544,505	0	0	0	6.00
7.00	Inventory	208,923	0	0	0	7.00
8.00	Prepaid expenses	165,736	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,962,665	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	197,980	0	0	0	17.00
18.00	Accumulated depreciation	-169,158	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	1,073,499	0	0	0	23.00
24.00	Accumulated depreciation	-599,951	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)	502,370	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	10,637	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,637	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	4,475,672	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	544,220	0	0	0	37.00
38.00	Salaries, wages, and fees payable	379,321	0	0	0	38.00
39.00	Payroll taxes payable	15,671	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	440,166	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,379,378	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,453,128	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,453,128	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,832,506	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,643,166				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)	1,643,166	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	4,475,672	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet G-1 | Date/Time Prepared: 1/14/2019 1:33 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1,760,662		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		338,852				2.00
3.00	Total (sum of line 1 and line 2)		-1,421,810		0		3.00
4.00	Additions (credit adjustments)	0		0		0	4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	3,064,976		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)		3,064,976		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,643,166		0		11.00
12.00	Deductions (debit adjustments)	0		0		0	12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,643,166		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 1/14/2019 1:33 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	25,262,247		25,262,247	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	25,262,247		25,262,247	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,262,247		25,262,247	17.00
18.00	Ancillary services	23,799,775	179,324	23,979,099	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	49,062,022	179,324	49,241,346	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,852,113		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)		13,852,113		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-2013 | Period: From 09/01/2017 To 08/31/2018 | Worksheet G-3 | Date/Time Prepared: 1/14/2019 1:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,241,346	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,512,091	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,729,255	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,852,113	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-122,858	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	9,909	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	1,035	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	14,348	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	70	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	436,348	24.00
25.00	Total other income (sum of lines 6-24)	461,710	25.00
26.00	Total (line 5 plus line 25)	338,852	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	338,852	29.00