

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: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/28/2017 4:16 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/28/2017 Time: 4:16 pm
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. ANTHONYS MEMORIAL HOSPITAL (14-0032) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-53,212	-226,946	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	-53,212	-226,946	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 4:13 pm					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL Zip Code: 62401		4.00 County: EFFINGHAM					
1.00 Street: 503 N MAPLE		2.00 City: EFFINGHAM									
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital	ST. ANTHONYS MEMORIAL HOSPITAL		140032	41180	1	07/01/1966	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	ST. ANTHONYS MEMORIAL HOSPITAL HHA		147661	99914		02/17/1997	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice	ST. ANTHONY MEMORIAL HOSPITAL HOSPI C		141658	99914		10/14/2014				14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2016	06/30/2017		20.00	
21.00	Type of Control (see instructions)						1			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							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.			2,077	484	0	0	3	80	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 4:13 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N		N		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		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N		N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						0.00	0.00	61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count					
	1.00	2.00	3.00	4.00						
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.20	
						1.00				
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 64-67. (see instructions)						N	63.00		
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))				
	1.00	2.00	3.00	4.00	5.00					
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
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.										
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))				
	1.00	2.00	3.00	4.00	5.00					
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 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 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00
				1.00			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N			81.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N			86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N			87.00
				V	XIX		
				1.00	2.00		
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
					1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
					1.00	2.00	3.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		0		0	
					1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 4:13 pm			
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y			140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NGS		Contractor's Number: 00131		141.00	
142.00	Street: 4936 LAVERNA ROAD	PO Box:				142.00	
143.00	City: SPRINGFIELD	State: IL		Zip Code: 62707		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y			144.00	
				1.00			
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			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0	168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				9.99	169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 4:13 pm
		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)	07/01/2016	06/30/2017	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 4:13 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		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.			Y			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	10/03/2017	Y	10/03/2017
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: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 4:13 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		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	FRED		HELFRICH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		211 N BROADWAY STE 600, ST LOUIS, MO	43.00

		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.	PARTNER	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: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 4:13 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	123	44,895	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)		123	44,895	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		133	48,545	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						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			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)		133			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 4:13 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	8,016	1,621	13,398			1.00
2.00 HMO and other (see instructions)	174	487				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)	8,016	1,621	13,398			7.00
8.00 INTENSIVE CARE UNIT	1,227	229	1,766			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		227	1,685			13.00
14.00 Total (see instructions)	9,243	2,077	16,849	0.00	613.62	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	44,637	7,937	60,110	0.00	103.16	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	19.82	24.00
24.10 HOSPICE (non-distinct part)	0	72	72			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	736.60	27.00
28.00 Observation Bed Days		263	1,712			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			304			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	80	159			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 4:13 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	2,596	613	5,125	1.00
2.00 HMO and other (see instructions)			42	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,596	613	5,125	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet S-3 Part II Date/Time Prepared: 11/28/2017 4:13 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 II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	42,688,028	0	42,688,028	1,532,127.00	27.86	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)		7,463,079	0	7,463,079	257,890.00	28.94	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		2,158,287	0	2,158,287	26,439.25	81.63	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		3,725,721	0	3,725,721	75,439.00	49.39	14.01
14.02	Related organization salaries		279,907	0	279,907	2,035.00	137.55	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)		14,042,039	0	14,042,039			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,897,537	0	2,897,537			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		1,577,887	0	1,577,887			25.50
25.51	Related organization wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	4,325	0	4,325	129.00	33.53	26.00
27.00	Administrative & General	5.00	5,232,236	0	5,232,236	208,548.00	25.09	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part II
Date/Time Prepared:
11/28/2017 4:13 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	822,573	0	822,573	35,816.00	22.97
31.00	Laundry & Linen Service	8.00	50,875	0	50,875	3,666.00	13.88
32.00	Housekeeping	9.00	661,401	0	661,401	53,077.00	12.46
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	850,291	-507,331	342,960	16,311.00	21.03
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	507,331	507,331	36,420.00	13.93
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	938,028	0	938,028	22,724.00	41.28
39.00	Central Services and Supply	14.00	20,920	0	20,920	671.00	31.18
40.00	Pharmacy	15.00	1,264,790	0	1,264,790	29,534.00	42.82
41.00	Medical Records & Medical Records Library	16.00	2,559,947	0	2,559,947	78,241.00	32.72
42.00	Social Service	17.00	0	0	0	0.00	0.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part III
Date/Time Prepared:
11/28/2017 4:13 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	42,688,028	0	42,688,028	1,532,127.00	27.86	1.00
2.00	Excluded area salaries (see instructions)	7,463,079	0	7,463,079	257,890.00	28.94	2.00
3.00	Subtotal salaries (line 1 minus line 2)	35,224,949	0	35,224,949	1,274,237.00	27.64	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,163,915	0	6,163,915	103,913.25	59.32	4.00
5.00	Subtotal wage-related costs (see inst.)	15,619,926	0	15,619,926	0.00	44.34	5.00
6.00	Total (sum of lines 3 thru 5)	57,008,790	0	57,008,790	1,378,150.25	41.37	6.00
7.00	Total overhead cost (see instructions)	12,405,386	0	12,405,386	485,137.00	25.57	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2017 4:13 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		179,277	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)		4,049,369	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)		8,981,067	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	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)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		776,182	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		2,208,426	17.00
18.00	Medicare Taxes - Employers Portion Only		618,976	18.00
19.00	Unemployment Insurance		50,491	19.00
20.00	State or Federal Unemployment Taxes		0	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		75,788	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		16,939,576	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: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part V Date/Time Prepared: 11/28/2017 4:13 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		2,158,287	16,939,576
2.00	Hospital		2,158,287	16,939,576
3.00	Subprovider - IPF			
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA		0	0
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice		0	0
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis		0	0
18.00	Other		0	0

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0032 Component CCN: 14-7661		Period: From 07/01/2016 To 06/30/2017		Worksheet S-4 Date/Time Prepared: 11/28/2017 4:13 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			EFFINGHAM		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	9,575	210	1,370	11,155	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,072.00	147.00	302.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			15.36	0.00	15.36	5.00
6.00	Direct Nursing Service			64.77	0.00	64.77	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			9.87	0.00	9.87	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			5.90	0.00	5.90	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			1.12	0.00	1.12	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			1.55	0.00	1.55	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			4.30	0.00	4.30	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			41180			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	15,249	3,424	344	261	19,278	21.00
22.00	Skilled Nursing Visit Charges	3,305,995	743,008	74,648	56,637	4,180,288	22.00
23.00	Physical Therapy Visits	7,310	669	40	116	8,135	23.00
24.00	Physical Therapy Visit Charges	1,688,610	154,539	9,240	26,796	1,879,185	24.00
25.00	Occupational Therapy Visits	2,232	269	5	30	2,536	25.00
26.00	Occupational Therapy Visit Charges	515,592	62,139	1,155	6,930	585,816	26.00
27.00	Speech Pathology Visits	212	12	2	1	227	27.00
28.00	Speech Pathology Visit Charges	48,972	2,772	462	231	52,437	28.00
29.00	Medical Social Service Visits	223	35	7	4	269	29.00
30.00	Medical Social Service Visit Charges	63,778	10,010	2,002	1,144	76,934	30.00
31.00	Home Health Aide Visits	2,264	927	6	5	3,202	31.00
32.00	Home Health Aide Visit Charges	237,720	97,335	630	525	336,210	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	27,490	5,336	404	417	33,647	33.00
34.00	Other Charges	121,717	56,748	1,668	2,367	182,500	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	5,982,384	1,126,551	89,805	94,630	7,293,370	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,745		141	30	1,916	36.00
37.00	Total Number of Outlier Episodes		137		6	143	37.00
38.00	Total Non-Routine Medical Supply Charges	57,967	14,668	1,809	959	75,403	38.00

HOSPITAL-BASED HOSPI CE IDENTIFICATION DATA		Provider CCN: 14-0032 Hospice CCN: 14-1658	Period: From 07/01/2016 To 06/30/2017	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 11/28/2017 4:13 pm
		Hospice I		

	Unduplicated Days	Hospice I				Total (sum of col.s. 1, 2 & 5)		
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility			All Other
		1.00	2.00	3.00	4.00			5.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
1.00	Hospice Continuous Home Care						1.00	
2.00	Hospice Routine Home Care						2.00	
3.00	Hospice Inpatient Respite Care						3.00	
4.00	Hospice General Inpatient Care						4.00	
5.00	Total Hospice Days						5.00	
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care						6.00	
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00	
8.00	Average Length of Stay (line 5 / line 6)						8.00	
9.00	Unduplicated census count						9.00	

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of col.s. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	11,167	676	379	12,222	11.00
12.00	Hospice Inpatient Respite Care	21	0	0	21	12.00
13.00	Hospice General Inpatient Care	176	15	9	200	13.00
14.00	Total Hospice Days	11,364	691	388	12,443	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	21	0	0	21	15.00
16.00	Hospice General Inpatient Care	176	15	9	200	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/28/2017 4:13 pm
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.321395	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			4,481,829	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			53,707,676	6.00
7.00	Medicaid cost (line 1 times line 6)			17,261,379	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			12,779,550	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			12,779,550	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,779,201	7,719,980	10,499,181	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	893,221	7,719,980	8,613,201	21.00
22.00	Payments received from patients for amounts previously written off as charity care	25,026	117,635	142,661	22.00
23.00	Cost of charity care (line 21 minus line 22)	868,195	7,602,345	8,470,540	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,257,770	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			388,560	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			597,785	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			659,985	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			421,341	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			8,891,881	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			21,671,431	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet A		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		5,855,038	5,855,038	-3,437,681	2,417,357	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	4,113,943	4,113,943	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,325	14,606,802	14,611,127	22,904	14,634,031	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,232,236	23,170,625	28,402,861	-45,407	28,357,454	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,866	6,866	0	6,866	6.00
7.00	00700	OPERATION OF PLANT	822,573	1,697,704	2,520,277	-79,403	2,440,874	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,875	424,631	475,506	-131	475,375	8.00
9.00	00900	HOUSEKEEPING	661,401	250,383	911,784	-10,961	900,823	9.00
10.00	01000	DIETARY	850,291	383,192	1,233,483	-822,504	410,979	10.00
11.00	01100	CAFETERIA	0	0	0	818,096	818,096	11.00
13.00	01300	NURSING ADMINISTRATION	938,028	66,030	1,004,058	0	1,004,058	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,920	1,383,707	1,404,627	-1,373,666	30,961	14.00
15.00	01500	PHARMACY	1,264,790	4,187,258	5,452,048	-3,847,012	1,605,036	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,559,947	1,193,534	3,753,481	-161	3,753,320	16.00
17.00	01700	SOCIAL SERVICE	0	4,855	4,855	0	4,855	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,038,910	887,554	6,926,464	-1,572,594	5,353,870	30.00
31.00	03100	INTENSIVE CARE UNIT	1,292,187	72,494	1,364,681	-34,537	1,330,144	31.00
43.00	04300	NURSERY	0	23,989	23,989	349,506	373,495	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,040,449	10,783,776	14,824,225	-9,573,996	5,250,229	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	105,771	105,771	963,080	1,068,851	52.00
53.00	05300	ANESTHESIOLOGY	1,762,444	2,404,535	4,166,979	-84,976	4,082,003	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,444,344	660,322	2,104,666	-143,022	1,961,644	54.00
54.01	03630	ULTRA SOUND	191,112	59,744	250,856	-30,967	219,889	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	180,389	302,895	483,284	-9,992	473,292	54.02
54.06	05404	PET SCAN	0	120,470	120,470	0	120,470	54.06
57.00	05700	CT SCAN	299,398	303,769	603,167	-11,165	592,002	57.00
58.00	05800	MRI	208,684	212,132	420,816	-3,682	417,134	58.00
59.00	05900	CARDIAC CATHETERIZATION	383,991	763,646	1,147,637	-660,379	487,258	59.00
60.00	06000	LABORATORY	1,266,533	1,891,639	3,158,172	-835,167	2,323,005	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	660,807	148,404	809,211	-51,656	757,555	65.00
66.00	06600	PHYSICAL THERAPY	1,307,217	430,470	1,737,687	-16,800	1,720,887	66.00
67.00	06700	OCCUPATIONAL THERAPY	340,769	36,424	377,193	-24,338	352,855	67.00
69.00	06900	ELECTROCARDIOLOGY	498,125	291,912	790,037	-19,901	770,136	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	128,805	29,311	158,116	-13,264	144,852	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	7,770,818	7,770,818	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	5,849,407	5,849,407	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,130,797	4,130,797	73.00
74.00	07400	RENAL DIALYSIS	0	31,482	31,482	-131	31,351	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	210,646	34,346	244,992	-6,367	238,625	76.01
76.03	03950	WOUND CARE	453,162	880,856	1,334,018	-84,141	1,249,877	76.03
76.97	07697	CARDIAC REHABILITATION	82,116	3,960	86,076	-2,252	83,824	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	129,301	48,398	177,699	-5,760	171,939	90.00
91.00	09100	EMERGENCY	1,900,174	2,131,395	4,031,569	-95,874	3,935,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,249,609	1,852,356	8,101,965	-309,375	7,792,590	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		597,652	597,652	-597,652	0	113.00
116.00	11600	HOSPICE	1,128,338	908,376	2,036,714	-213,637	1,823,077	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,602,896	79,248,703	121,851,599	0	121,851,599	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	21,935	21,935	0	21,935	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	85,132	3,532,861	3,617,993	0	3,617,993	194.00
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	42,688,028	82,803,499	125,491,527	0	125,491,527	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet A
Date/Time Prepared:
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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	-216,589	2,200,768	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-382,123	3,731,820	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	633,007	15,267,038	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,825,795	26,531,659	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,866	6.00
7.00	00700	OPERATION OF PLANT	0	2,440,874	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	475,375	8.00
9.00	00900	HOUSEKEEPING	-16	900,807	9.00
10.00	01000	DIETARY	0	410,979	10.00
11.00	01100	CAFETERIA	0	818,096	11.00
13.00	01300	NURSING ADMINISTRATION	-704	1,003,354	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,961	14.00
15.00	01500	PHARMACY	0	1,605,036	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-62,069	3,691,251	16.00
17.00	01700	SOCIAL SERVICE	-3,200	1,655	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	5,353,870	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,330,144	31.00
43.00	04300	NURSERY	0	373,495	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,250,229	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,068,851	52.00
53.00	05300	ANESTHESIOLOGY	-3,948,124	133,879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,056	1,964,700	54.00
54.01	03630	ULTRA SOUND	0	219,889	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	473,292	54.02
54.06	05404	PET SCAN	0	120,470	54.06
57.00	05700	CT SCAN	0	592,002	57.00
58.00	05800	MRI	0	417,134	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	487,258	59.00
60.00	06000	LABORATORY	-23,782	2,299,223	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	757,555	65.00
66.00	06600	PHYSICAL THERAPY	-1,000	1,719,887	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	352,855	67.00
69.00	06900	ELECTROCARDIOLOGY	-160,306	609,830	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-7,975	136,877	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	7,770,818	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	5,849,407	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-8,663	4,122,134	73.00
74.00	07400	RENAL DIALYSIS	0	31,351	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03650	VASCULAR LAB	0	238,625	76.01
76.03	03950	WOUND CARE	-268,086	981,791	76.03
76.97	07697	CARDIAC REHABILITATION	0	83,824	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	171,939	90.00
91.00	09100	EMERGENCY	-1,655,565	2,280,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-2,387	7,790,203	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	1,823,077	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,930,321	113,921,278	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	21,935	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	0	3,617,993	194.00
194.02	07952	MEALS ON WHEELS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-7,930,321	117,561,206	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - PERSONNEL COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44,957	1.00
	O		0	44,957	
B - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	507,331	310,765	1.00
	O		507,331	310,765	
C - PHARMACY DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,130,797	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	O		0	4,130,797	
D - CENTRAL SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	7,770,818	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
	O		0	7,770,818	
E - PROPERTY INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	78,610	1.00
	TOTALS		0	78,610	

RECLASSIFICATIONS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-6

Date/Time Prepared:
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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	216,616	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	381,036	2.00
	0		0	597,652	
G - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,732,907	1.00
	0		0	3,732,907	
H - LABOR & DELIVERY					
1.00	NURSERY	43.00	366,298	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,030,969	0	2.00
	0		1,397,267	0	
I - IMPLANT RECLASS					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	5,849,407	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	5,849,407	
500.00	Grand Total: Increases		1,904,598	22,515,913	500.00

RECLASSIFICATIONS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-6
Date/Time Prepared:
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Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - PERSONNEL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	44,957		3	1.00
	O		0	44,957			
B - CAFETERIA COSTS							
1.00	DIETARY	10.00	507,331	310,765		0	1.00
	O		507,331	310,765			
C - PHARMACY DRUGS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	21,769		0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	450		0	2.00
3.00	DIETARY	10.00	0	185		0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,291		0	4.00
5.00	PHARMACY	15.00	0	3,818,663		0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	16,572		0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	3,226		0	7.00
8.00	OPERATING ROOM	50.00	0	20,910		0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	87		0	9.00
10.00	ANESTHESIOLOGY	53.00	0	39,751		0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,502		0	11.00
12.00	ULTRA SOUND	54.01	0	30		0	12.00
13.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	7,976		0	13.00
14.00	MRI	58.00	0	537		0	14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	745		0	15.00
16.00	LABORATORY	60.00	0	702		0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	34		0	17.00
18.00	PHYSICAL THERAPY	66.00	0	44		0	18.00
19.00	ELECTROCARDIOLOGY	69.00	0	1,108		0	19.00
20.00	WOUND CARE	76.03	0	6,790		0	20.00
21.00	CARDIAC REHABILITATION	76.97	0	26		0	21.00
22.00	CLINIC	90.00	0	12		0	22.00
23.00	EMERGENCY	91.00	0	7,995		0	23.00
24.00	HOME HEALTH AGENCY	101.00	0	4,726		0	24.00
25.00	HOSPICE	116.00	0	163,666		0	25.00
	O		0	4,130,797			
D - CENTRAL SUPPLY							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	284		0	1.00
2.00	OPERATION OF PLANT	7.00	0	793		0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	131		0	3.00
4.00	HOUSEKEEPING	9.00	0	10,961		0	4.00
5.00	DIETARY	10.00	0	4,223		0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,365,375		0	6.00
7.00	PHARMACY	15.00	0	28,349		0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	161		0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	158,755		0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	31,311		0	10.00
11.00	NURSERY	43.00	0	16,792		0	11.00
12.00	OPERATING ROOM	50.00	0	3,767,624		0	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	67,802		0	13.00
14.00	ANESTHESIOLOGY	53.00	0	45,225		0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	136,520		0	15.00
16.00	ULTRA SOUND	54.01	0	30,937		0	16.00
17.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	2,016		0	17.00
18.00	CT SCAN	57.00	0	11,165		0	18.00
19.00	MRI	58.00	0	3,145		0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	595,689		0	20.00
21.00	LABORATORY	60.00	0	834,465		0	21.00
22.00	RESPIRATORY THERAPY	65.00	0	51,622		0	22.00
23.00	PHYSICAL THERAPY	66.00	0	16,756		0	23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	24,338		0	24.00
25.00	ELECTROCARDIOLOGY	69.00	0	18,793		0	25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	13,264		0	26.00
27.00	RENAL DIALYSIS	74.00	0	131		0	27.00
28.00	VASCULAR LAB	76.01	0	6,367		0	28.00
29.00	WOUND CARE	76.03	0	77,351		0	29.00
30.00	CARDIAC REHABILITATION	76.97	0	2,226		0	30.00
31.00	CLINIC	90.00	0	5,748		0	31.00
32.00	EMERGENCY	91.00	0	87,879		0	32.00
33.00	HOME HEALTH AGENCY	101.00	0	304,649		0	33.00
34.00	HOSPICE	116.00	0	49,971		0	34.00
	O		0	7,770,818			

RECLASSIFICATIONS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-6

Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
E - PROPERTY INSURANCE EXPENSE							
1.00	OPERATION OF PLANT	7.00	0	78,610	9		1.00
	TOTALS		0	78,610			
F - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	597,652	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	597,652			
G - DEPRECIATION EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,732,907	9		1.00
	0		0	3,732,907			
H - LABOR & DELIVERY							
1.00	ADULTS & PEDIATRICS	30.00	1,397,267	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,397,267	0			
I - IMPLANT RECLASS							
1.00	OPERATING ROOM	50.00	0	5,785,462	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	63,945	0		2.00
	TOTALS		0	5,849,407			
500.00	Grand Total: Decreases		1,904,598	22,515,913			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,699,574	0	0	0	0	1.00
2.00	Land Improvements	3,431,092	0	0	0	0	2.00
3.00	Buildings and Fixtures	86,347,013	993,131	0	993,131	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	74,624,343	2,343,784	0	2,343,784	117,865	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	167,102,022	3,336,915	0	3,336,915	117,865	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	167,102,022	3,336,915	0	3,336,915	117,865	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,699,574	0				1.00
2.00	Land Improvements	3,431,092	2,224,783				2.00
3.00	Buildings and Fixtures	87,340,144	31,653,301				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	14,103,995				5.00
6.00	Movable Equipment	76,850,262	65,667,425				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	170,321,072	113,649,504				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	170,321,072	113,649,504				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part II
Date/Time Prepared:
11/28/2017 4:13 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	5,855,038	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,855,038	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	5,855,038				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5,855,038				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part III
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	89,995,790	0	89,995,790	0.528389	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	80,325,281	0	80,325,281	0.471611	0	2.00
3.00	Total (sum of lines 1-2)	170,321,071	0	170,321,071	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,200,768	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,731,820	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,932,588	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,200,768	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,731,820	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	5,932,588	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8

Date/Time Prepared:
11/28/2017 4:13 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
				Cost Center		Line #		
				1.00	2.00	3.00		4.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-216,589	CAP REL COSTS-BLDG & FIXT		1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-381,063	CAP REL COSTS-MVBLE EQUIP		2.00	9	2.00
3.00	Investment income - other (chapter 2)		0			0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0			0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-7,895	ADMINISTRATIVE & GENERAL		5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,060	CAP REL COSTS-MVBLE EQUIP		2.00	9	7.00
8.00	Television and radio service (chapter 21)		0			0.00	0	8.00
9.00	Parking lot (chapter 21)		0			0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,755,179				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	2,401,311				0	12.00
13.00	Laundry and linen service		0			0.00	0	13.00
14.00	Cafeteria-employees and guests		0			0.00	0	14.00
15.00	Rental of quarters to employee and others		0			0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00	Sale of drugs to other than patients		0			0.00	0	17.00
18.00	Sale of medical records and abstracts		0			0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00	Vending machines		0			0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		28.00
29.00	Physicians' assistant		0			0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00	MISC INCOME	B	-720,675	ADMINISTRATIVE & GENERAL		5.00	0	33.00
33.01	MISC INCOME	B	-16	HOUSEKEEPING		9.00	0	33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.02	MISC INCOME	B	-704	NURSING ADMINISTRATION	13.00	0 33.02
33.03	MISC INCOME	B	-61,969	MEDICAL RECORDS & LIBRARY	16.00	0 33.03
33.04	MISC INCOME	B	-1,805,016	ANESTHESIOLOGY	53.00	0 33.04
33.05	MISC INCOME	B	5,850	RADIOLOGY-DIAGNOSTIC	54.00	0 33.05
33.06	MISC INCOME	B	-865	LABORATORY	60.00	0 33.06
33.07	MISC INCOME	B	-1,000	PHYSICAL THERAPY	66.00	0 33.07
33.08	MISC INCOME	B	-4,020	DRUGS CHARGED TO PATIENTS	73.00	0 33.08
33.09	MISC INCOME	B	-1,941	HOME HEALTH AGENCY	101.00	0 33.09
33.10	TELEPHONE EMPLOYEE BENEFITS	A	-4,643	DRUGS CHARGED TO PATIENTS	73.00	0 33.10
33.11	TELEPHONE A&G SALARIES	A	-12,565	EMERGENCY	91.00	0 33.11
33.12	TELEPHONE A&G OTHER EXPENSE	A	-446	HOME HEALTH AGENCY	101.00	0 33.12
33.13	TELEVISION EMPLOYEE BENEFITS	A	-822	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.13
33.14	TELEVISION A&G SALARIES	A	-2,225	ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15	TELEVISION A&G OTHER EXPENSE	A	-462	ADMINISTRATIVE & GENERAL	5.00	0 33.15
33.16	TELEVISION A&G OTHER CABLE EXPENSE	A	-17,126	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.16
33.17	PHYSICIAN RECRUITMENT	A	-2,986	ADMINISTRATIVE & GENERAL	5.00	0 33.17
33.18	MEDICAID TAX ASSESSMENT	A	-3,570,985	ADMINISTRATIVE & GENERAL	5.00	0 33.18
33.19	SELF-INS TO HOSP/EMP CLAIMS	A	-3,531,632	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.19
33.20	LOBBYING EXPENSES	A	-26,447	ADMINISTRATIVE & GENERAL	5.00	0 33.20
33.21	COUNTRY CLUB FEES	A	-325	ADMINISTRATIVE & GENERAL	5.00	0 33.21
33.22	ALCOHOL BEVERAGE COST	A	-2,637	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.22
33.23	DEFINED PENSION ADJUSTMENT	A	4,324,498	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.23
33.24	CRNA EXPENSE	A	-493,007	ANESTHESIOLOGY	53.00	0 33.24
33.25	PUBLIC RELATIONS/MARKETING	A	-434	ADMINISTRATIVE & GENERAL	5.00	0 33.25
33.26	PUBLIC RELATIONS/MARKETING	A	-100	MEDICAL RECORDS & LIBRARY	16.00	0 33.26
33.27	PUBLIC RELATIONS/MARKETING	A	-3,200	SOCIAL SERVICE	17.00	0 33.27
33.28	GIFT SHOP REVENUE	B	-33,946	ADMINISTRATIVE & GENERAL	5.00	0 33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,930,321			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: 14-0032
 Period: From 07/01/2016 To 06/30/2017
 Worksheet A-8-1
 Date/Time Prepared: 11/28/2017 4:13 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	HEALTH & DENTAL PREMIUM	7,500,360	7,499,233 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - ISC	7,828,234	5,288,776 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CONTRACTED SERVICES - SSC	2,585,615	2,724,889 3.00
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,914,209	15,512,898 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.

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

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

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

6.00	G	HSHS	100.00	HSHS	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	SISTER				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: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8-1

Date/Time Prepared:
11/28/2017 4:13 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	1,127	0		1.00
2.00	2,539,458	0		2.00
3.00	-139,274	0		3.00
4.00	0	0		4.00
5.00	2,401,311			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8-2

Date/Time Prepared:
11/28/2017 4:13 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	53.00	ANESTHESIOLOGY	1,650,101	1,650,101	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	2,794	2,794	0	0	0	2.00
3.00	60.00	LABORATORY	22,917	22,917	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	160,306	160,306	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	7,975	7,975	0	0	0	5.00
6.00	76.03	WOUND CARE	268,086	268,086	0	0	0	6.00
7.00	91.00	EMERGENCY	1,643,000	1,643,000	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			3,755,179	3,755,179	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	5.00
6.00	76.03	WOUND CARE	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	1,650,101		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,794		2.00
3.00	60.00	LABORATORY	0	0	0	22,917		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	160,306		4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	7,975		5.00
6.00	76.03	WOUND CARE	0	0	0	268,086		6.00
7.00	91.00	EMERGENCY	0	0	0	1,643,000		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,755,179		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,200,768	2,200,768			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,731,820		3,731,820		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	15,267,038	5,305	0	15,272,343	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,531,659	616,248	579,918	1,872,110	29,599,935
6.00 00600	MAINTENANCE & REPAIRS	6,866	0	8,843	0	15,709
7.00 00700	OPERATION OF PLANT	2,440,874	410,338	1,300,326	294,319	4,445,857
8.00 00800	LAUNDRY & LINEN SERVICE	475,375	11,065	1,621	18,203	506,264
9.00 00900	HOUSEKEEPING	900,807	0	1,337	236,651	1,138,795
10.00 01000	DIETARY	410,979	47,593	13,782	122,712	595,066
11.00 01100	CAFETERIA	818,096	10,922	0	181,525	1,010,543
13.00 01300	NURSING ADMINISTRATION	1,003,354	9,920	1,339	335,629	1,350,242
14.00 01400	CENTRAL SERVICES & SUPPLY	30,961	0	0	7,485	38,446
15.00 01500	PHARMACY	1,605,036	0	0	452,546	2,057,582
16.00 01600	MEDICAL RECORDS & LIBRARY	3,691,251	14,365	29,706	915,957	4,651,279
17.00 01700	SOCIAL SERVICE	1,655	0	0	0	1,655
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,353,870	281,362	143,358	1,660,794	7,439,384
31.00 03100	INTENSIVE CARE UNIT	1,330,144	29,834	71,748	462,348	1,894,074
43.00 04300	NURSERY	373,495	0	1,346	131,063	505,904
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,250,229	208,360	556,453	1,445,685	7,460,727
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,068,851	30,274	32,235	368,884	1,500,244
53.00 05300	ANESTHESIOLOGY	133,879	1,328	56,043	630,608	821,858
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,964,700	104,536	331,280	516,791	2,917,307
54.01 03630	ULTRA SOUND	219,889	3,713	50,359	68,380	342,341
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	473,292	15,117	3,418	64,544	556,371
54.06 05404	PET SCAN	120,470	1,355	0	0	121,825
57.00 05700	CT SCAN	592,002	9,493	5,339	107,126	713,960
58.00 05800	MRI	417,134	34,170	7,748	74,668	533,720
59.00 05900	CARDIAC CATHETERIZATION	487,258	12,549	31,701	137,393	668,901
60.00 06000	LABORATORY	2,299,223	39,719	51,909	453,169	2,844,020
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	757,555	6,295	18,660	236,439	1,018,949
66.00 06600	PHYSICAL THERAPY	1,719,887	54,206	12,826	467,726	2,254,645
67.00 06700	OCCUPATIONAL THERAPY	352,855	0	0	121,928	474,783
69.00 06900	ELECTROCARDIOLOGY	609,830	34,014	35,909	178,231	857,984
70.00 07000	ELECTROENCEPHALOGRAPHY	136,877	4,628	4,742	46,087	192,334
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	7,770,818	17,414	0	0	7,788,232
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,849,407	0	0	0	5,849,407
73.00 07300	DRUGS CHARGED TO PATIENTS	4,122,134	25,450	24,020	0	4,171,604
74.00 07400	RENAL DIALYSIS	31,351	3,029	0	0	34,380
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01 03650	VASCULAR LAB	238,625	2,582	37,280	75,370	353,857
76.03 03950	WOUND CARE	981,791	23,424	5,035	162,143	1,172,393
76.97 07697	CARDIAC REHABILITATION	83,824	4,472	37,463	29,381	155,140
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	171,939	6,579	539	46,264	225,321
91.00 09100	EMERGENCY	2,280,130	66,951	88,615	679,888	3,115,584
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	7,790,203	27,035	106,478	2,236,113	10,159,829
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	1,823,077	6,179	152	403,723	2,233,131
118.00	SUBTOTALS (SUM OF LINES 1-117)	113,921,278	2,179,824	3,651,528	15,241,883	113,789,582
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	21,935	3,747	396	0	26,078
194.00 07950	PHILANTHROPY DEVELOPMENT	3,617,993	17,197	79,896	30,460	3,745,546
194.02 07952	MEALS ON WHEELS	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	117,561,206	2,200,768	3,731,820	15,272,343	117,561,206

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part I Date/Time Prepared: 11/28/2017 4:13 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,599,935				5.00
6.00	00600	MAINTENANCE & REPAIRS	5,286	20,995			6.00
7.00	00700	OPERATION OF PLANT	1,496,080	5,454	5,947,391		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	170,363	148	56,299	733,074	8.00
9.00	00900	HOUSEKEEPING	383,217	0	0	0	1,522,012
10.00	01000	DIETARY	200,246	633	242,158	5,423	62,353
11.00	01100	CAFETERIA	340,059	146	55,575	0	14,361
13.00	01300	NURSING ADMINISTRATION	454,371	132	50,473	0	13,045
14.00	01400	CENTRAL SERVICES & SUPPLY	12,938	0	0	0	0
15.00	01500	PHARMACY	692,399	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,565,207	191	73,089	0	18,909
17.00	01700	SOCIAL SERVICE	557	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,503,435	3,741	1,431,607	231,731	369,866
31.00	03100	INTENSIVE CARE UNIT	637,377	396	151,797	36,567	39,195
43.00	04300	NURSERY	170,242	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,510,617	2,771	1,060,166	186,332	273,884
52.00	05200	DELIVERY ROOM & LABOR ROOM	504,849	403	154,038	52,035	39,793
53.00	05300	ANESTHESIOLOGY	276,564	17	6,757	0	1,735
54.00	05400	RADIOLOGY-DIAGNOSTIC	981,706	1,389	531,893	25,881	137,391
54.01	03630	ULTRA SOUND	115,202	49	18,893	3,904	4,907
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	187,225	202	76,916	2,461	19,867
54.06	05404	PET SCAN	40,995	17	6,895	0	1,795
57.00	05700	CT SCAN	240,255	127	48,301	8,410	12,506
58.00	05800	MRI	179,603	454	173,862	18,993	44,939
59.00	05900	CARDIAC CATHETERIZATION	225,093	167	63,849	206	16,516
60.00	06000	LABORATORY	957,044	528	202,097	63	52,240
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	342,888	83	32,028	12,209	8,258
66.00	06600	PHYSICAL THERAPY	758,713	721	275,807	7,766	71,269
67.00	06700	OCCUPATIONAL THERAPY	159,770	0	0	2,236	0
69.00	06900	ELECTROCARDIOLOGY	288,721	452	173,069	3,807	44,700
70.00	07000	ELECTROENCEPHALOGRAPHY	64,723	61	23,547	76	6,104
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,620,826	231	88,603	0	22,918
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,968,390	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,403,791	339	129,491	0	33,450
74.00	07400	RENAL DIALYSIS	11,569	40	15,411	0	4,009
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03650	VASCULAR LAB	119,077	35	13,135	2,101	3,411
76.03	03950	WOUND CARE	394,523	311	119,183	6,534	30,817
76.97	07697	CARDIAC REHABILITATION	52,206	59	22,754	782	5,864
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	75,823	87	33,476	1,497	8,677
91.00	09100	EMERGENCY	1,048,428	890	340,656	122,231	88,024
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,418,891	360	137,559	0	35,545
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	751,473	82	31,442	537	8,138
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,330,742	20,716	5,840,826	731,782	1,494,486
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	8,776	50	19,065	0	4,907
194.00	07950	PHILANTHROPY DEVELOPMENT	1,260,417	229	87,500	1,292	22,619
194.02	07952	MEALS ON WHEELS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	29,599,935	20,995	5,947,391	733,074	1,522,012

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part I Date/Time Prepared: 11/28/2017 4:13 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,105,879					10.00
11.00	01100	CAFETERIA	0	1,420,684				11.00
13.00	01300	NURSING ADMINISTRATION	0	27,339	1,895,602			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	51,384		14.00
15.00	01500	PHARMACY	0	0	0	0	2,749,981	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	94,358	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	977,703	218,764	574,800	561	11,883	30.00
31.00	03100	INTENSIVE CARE UNIT	128,176	47,003	99,570	111	2,301	31.00
43.00	04300	NURSERY	0	13,645	0	59	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	165,289	340,735	33,755	14,808	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	38,400	0	240	0	52.00
53.00	05300	ANESTHESIOLOGY	0	25,684	0	159	28,358	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	68,975	0	556	4,638	54.00
54.01	03630	ULTRA SOUND	0	6,145	0	109	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	7,399	0	860	5,690	54.02
54.06	05404	PET SCAN	0	0	0	0	0	54.06
57.00	05700	CT SCAN	0	12,992	0	275	0	57.00
58.00	05800	MRI	0	8,402	0	145	383	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,171	0	2,330	531	59.00
60.00	06000	LABORATORY	0	66,868	0	3,979	501	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	34,312	0	280	9	65.00
66.00	06600	PHYSICAL THERAPY	0	54,352	0	59	31	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,265	0	86	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	20,040	0	66	775	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,292	0	47	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	803	0	4,852	312	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,616	0	969	2,548,878	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	0	6,872	0	22	0	76.01
76.03	03950	WOUND CARE	0	18,811	0	273	4,831	76.03
76.97	07697	CARDIAC REHABILITATION	0	2,709	0	8	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,966	0	20	0	90.00
91.00	09100	EMERGENCY	0	98,220	214,830	310	5,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	258,747	558,422	1,075	3,594	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	49,712	107,245	177	116,758	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,105,879	1,418,151	1,895,602	51,384	2,749,981	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	0	2,533	0	0	0	194.00
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,105,879	1,420,684	1,895,602	51,384	2,749,981	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	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
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,403,034				16.00
17.00	01700	SOCIAL SERVICE	0	2,212			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,676,290	1,961	19,441,726	0	30.00
31.00	03100	INTENSIVE CARE UNIT	726,744	251	3,763,562	0	31.00
43.00	04300	NURSERY	0	0	689,850	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	12,049,084	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,290,002	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,161,132	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,669,736	0	54.00
54.01	03630	ULTRA SOUND	0	0	491,550	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	856,991	0	54.02
54.06	05404	PET SCAN	0	0	171,527	0	54.06
57.00	05700	CT SCAN	0	0	1,036,826	0	57.00
58.00	05800	MRI	0	0	960,501	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	991,764	0	59.00
60.00	06000	LABORATORY	0	0	4,127,340	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	1,449,016	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,423,363	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	649,140	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,389,614	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	292,184	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	10,526,777	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	7,817,797	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,324,138	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	65,409	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	0	0	498,510	0	76.01
76.03	03950	WOUND CARE	0	0	1,747,676	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	239,522	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	349,867	0	90.00
91.00	09100	EMERGENCY	0	0	5,034,873	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	14,574,022	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	3,298,695	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,403,034	2,212	112,382,194	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	58,876	0	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	0	0	5,120,136	0	194.00
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,403,034	2,212	117,561,206	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part II
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,305	0	5,305	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,299,758	616,248	579,918	3,495,924	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	8,843	8,843	6.00
7.00 00700	OPERATION OF PLANT	11,925	410,338	1,300,326	1,722,589	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,065	1,621	12,686	8.00
9.00 00900	HOUSEKEEPING	0	0	1,337	1,337	9.00
10.00 01000	DIETARY	686	47,593	13,782	62,061	10.00
11.00 01100	CAFETERIA	0	10,922	0	10,922	11.00
13.00 01300	NURSING ADMINISTRATION	0	9,920	1,339	11,259	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	259,690	0	0	259,690	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	14,365	29,706	44,071	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	839	281,362	143,358	425,559	30.00
31.00 03100	INTENSIVE CARE UNIT	0	29,834	71,748	101,582	31.00
43.00 04300	NURSERY	0	0	1,346	1,346	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	277,991	208,360	556,453	1,042,804	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	30,274	32,235	62,509	52.00
53.00 05300	ANESTHESIOLOGY	0	1,328	56,043	57,371	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	221,654	104,536	331,280	657,470	54.00
54.01 03630	ULTRA SOUND	0	3,713	50,359	54,072	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	15,117	3,418	18,535	54.02
54.06 05404	PET SCAN	0	1,355	0	1,355	54.06
57.00 05700	CT SCAN	0	9,493	5,339	14,832	57.00
58.00 05800	MRI	0	34,170	7,748	41,918	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	12,549	31,701	44,250	59.00
60.00 06000	LABORATORY	117,591	39,719	51,909	209,219	60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	64,812	6,295	18,660	89,767	65.00
66.00 06600	PHYSICAL THERAPY	143,169	54,206	12,826	210,201	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	34,014	35,909	69,923	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	7,978	4,628	4,742	17,348	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	17,414	0	17,414	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	259,690	25,450	24,020	309,160	73.00
74.00 07400	RENAL DIALYSIS	0	3,029	0	3,029	74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01 03650	VASCULAR LAB	0	2,582	37,280	39,862	76.01
76.03 03950	WOUND CARE	0	23,424	5,035	28,459	76.03
76.97 07697	CARDIAC REHABILITATION	0	4,472	37,463	41,935	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	6,579	539	7,118	90.00
91.00 09100	EMERGENCY	0	66,951	88,615	155,566	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	60,713	27,035	106,478	194,226	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	7,730	6,179	152	14,061	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	3,734,226	2,179,824	3,651,528	9,565,578	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	3,747	396	4,143	190.00
194.00 07950	PHILANTHROPY DEVELOPMENT	0	17,197	79,896	97,093	194.00
194.02 07952	MEALS ON WHEELS	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,734,226	2,200,768	3,731,820	9,666,814	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/28/2017 4:13 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,496,573				5.00
6.00	00600	MAINTENANCE & REPAIRS	624	9,467			6.00
7.00	00700	OPERATION OF PLANT	176,727	2,459	1,901,877		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,125	67	18,003	50,887	8.00
9.00	00900	HOUSEKEEPING	45,268	0	0	0	46,687
10.00	01000	DIETARY	23,654	285	77,438	376	1,913
11.00	01100	CAFETERIA	40,170	66	17,772	0	441
13.00	01300	NURSING ADMINISTRATION	53,673	60	16,140	0	400
14.00	01400	CENTRAL SERVICES & SUPPLY	1,528	0	0	0	0
15.00	01500	PHARMACY	81,791	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	184,893	86	23,373	0	580
17.00	01700	SOCIAL SERVICE	66	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	295,723	1,687	457,805	16,087	11,346
31.00	03100	INTENSIVE CARE UNIT	75,291	179	48,542	2,538	1,202
43.00	04300	NURSERY	20,110	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	296,571	1,249	339,024	12,934	8,401
52.00	05200	DELIVERY ROOM & LABOR ROOM	59,636	182	49,259	3,612	1,221
53.00	05300	ANESTHESIOLOGY	32,670	8	2,161	0	53
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,966	626	170,091	1,797	4,214
54.01	03630	ULTRA SOUND	13,608	22	6,042	271	151
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	22,116	91	24,596	171	609
54.06	05404	PET SCAN	4,843	8	2,205	0	55
57.00	05700	CT SCAN	28,381	57	15,446	584	384
58.00	05800	MRI	21,216	205	55,598	1,318	1,378
59.00	05900	CARDIAC CATHETERIZATION	26,589	75	20,418	14	507
60.00	06000	LABORATORY	113,053	238	64,627	4	1,602
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	40,504	38	10,242	848	253
66.00	06600	PHYSICAL THERAPY	89,624	325	88,198	539	2,186
67.00	06700	OCCUPATIONAL THERAPY	18,873	0	0	155	0
69.00	06900	ELECTROCARDIOLOGY	34,106	204	55,344	264	1,371
70.00	07000	ELECTROENCEPHALOGRAPHY	7,645	27	7,530	5	187
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	309,590	104	28,334	0	703
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	232,520	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	165,825	153	41,409	0	1,026
74.00	07400	RENAL DIALYSIS	1,367	18	4,928	0	123
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03650	VASCULAR LAB	14,066	16	4,200	146	105
76.03	03950	WOUND CARE	46,604	140	38,113	454	945
76.97	07697	CARDIAC REHABILITATION	6,167	27	7,276	54	180
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	8,957	39	10,705	104	266
91.00	09100	EMERGENCY	123,848	401	108,936	8,485	2,700
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	403,890	162	43,989	0	1,090
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	88,769	37	10,055	37	250
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,346,647	9,341	1,867,799	50,797	45,842
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,037	23	6,097	0	151
194.00	07950	PHILANTHROPY DEVELOPMENT	148,889	103	27,981	90	694
194.02	07952	MEALS ON WHEELS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,496,573	9,467	1,901,877	50,887	46,687

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/28/2017 4:13 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	165,770					10.00
11.00	01100	CAFETERIA	0	69,434				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,336	82,984			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,531		14.00
15.00	01500	PHARMACY	0	0	0	0	341,638	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,612	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	146,557	10,692	25,163	17	1,476	30.00
31.00	03100	INTENSIVE CARE UNIT	19,213	2,297	4,359	3	286	31.00
43.00	04300	NURSERY	0	667	0	2	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,078	14,916	1,007	1,840	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,877	0	7	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,255	0	5	3,523	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,371	0	17	576	54.00
54.01	03630	ULTRA SOUND	0	300	0	3	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	362	0	26	707	54.02
54.06	05404	PET SCAN	0	0	0	0	0	54.06
57.00	05700	CT SCAN	0	635	0	8	0	57.00
58.00	05800	MRI	0	411	0	4	48	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	693	0	69	66	59.00
60.00	06000	LABORATORY	0	3,268	0	118	62	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,677	0	8	1	65.00
66.00	06600	PHYSICAL THERAPY	0	2,656	0	2	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	599	0	3	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	979	0	2	96	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	259	0	1	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	39	0	144	39	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,741	0	29	316,654	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	0	336	0	1	0	76.01
76.03	03950	WOUND CARE	0	919	0	8	600	76.03
76.97	07697	CARDIAC REHABILITATION	0	132	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	243	0	1	0	90.00
91.00	09100	EMERGENCY	0	4,800	9,405	9	708	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	12,646	24,446	32	447	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,430	4,695	5	14,505	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	165,770	69,310	82,984	1,531	341,638	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	0	124	0	0	0	194.00
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	165,770	69,434	82,984	1,531	341,638	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/28/2017 4:13 pm	
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	257,932					16.00
17.00	01700	SOCIAL SERVICE	0	66				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	228,657	59	1,621,404	0	1,621,404	30.00
31.00	03100	INTENSIVE CARE UNIT	29,275	7	284,934	0	284,934	31.00
43.00	04300	NURSERY	0	0	22,170	0	22,170	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	1,727,325	0	1,727,325	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	178,431	0	178,431	52.00
53.00	05300	ANESTHESIOLOGY	0	0	97,265	0	97,265	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	954,307	0	954,307	54.00
54.01	03630	ULTRA SOUND	0	0	74,493	0	74,493	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	67,235	0	67,235	54.02
54.06	05404	PET SCAN	0	0	8,466	0	8,466	54.06
57.00	05700	CT SCAN	0	0	60,364	0	60,364	57.00
58.00	05800	MRI	0	0	122,122	0	122,122	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	92,729	0	92,729	59.00
60.00	06000	LABORATORY	0	0	392,348	0	392,348	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	143,420	0	143,420	65.00
66.00	06600	PHYSICAL THERAPY	0	0	393,897	0	393,897	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	19,672	0	19,672	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	162,351	0	162,351	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	33,018	0	33,018	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	356,367	0	356,367	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	232,520	0	232,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	835,997	0	835,997	73.00
74.00	07400	RENAL DIALYSIS	0	0	9,465	0	9,465	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	0	0	58,758	0	58,758	76.01
76.03	03950	WOUND CARE	0	0	116,298	0	116,298	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	55,781	0	55,781	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	27,449	0	27,449	90.00
91.00	09100	EMERGENCY	0	0	415,094	0	415,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	681,714	0	681,714	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	134,984	0	134,984	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	257,932	66	9,380,378	0	9,380,378	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	11,451	0	11,451	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	0	0	274,985	0	274,985	194.00
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	257,932	66	9,666,814	0	9,666,814	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	324,802					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		5,855,038				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	783	0	42,683,703			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	90,950	909,862	5,232,236	-29,599,935	87,961,271	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	13,875	0	0	15,709	6.00
7.00 00700	OPERATION OF PLANT	60,560	2,040,142	822,573	0	4,445,857	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,633	2,543	50,875	0	506,264	8.00
9.00 00900	HOUSEKEEPING	0	2,098	661,401	0	1,138,795	9.00
10.00 01000	DIETARY	7,024	21,623	342,960	0	595,066	10.00
11.00 01100	CAFETERIA	1,612	0	507,331	0	1,010,543	11.00
13.00 01300	NURSING ADMINISTRATION	1,464	2,101	938,028	0	1,350,242	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	20,920	0	38,446	14.00
15.00 01500	PHARMACY	0	0	1,264,790	0	2,057,582	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,120	46,607	2,559,947	0	4,651,279	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	1,655	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	41,525	224,921	4,641,643	0	7,439,384	30.00
31.00 03100	INTENSIVE CARE UNIT	4,403	112,569	1,292,187	0	1,894,074	31.00
43.00 04300	NURSERY	0	2,112	366,298	0	505,904	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	30,751	873,047	4,040,449	0	7,460,727	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,468	50,575	1,030,969	0	1,500,244	52.00
53.00 05300	ANESTHESIOLOGY	196	87,929	1,762,444	0	821,858	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	15,428	519,762	1,444,344	0	2,917,307	54.00
54.01 03630	ULTRA SOUND	548	79,010	191,112	0	342,341	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	2,231	5,363	180,389	0	556,371	54.02
54.06 05404	PET SCAN	200	0	0	0	121,825	54.06
57.00 05700	CT SCAN	1,401	8,377	299,398	0	713,960	57.00
58.00 05800	MRI	5,043	12,157	208,684	0	533,720	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,852	49,738	383,991	0	668,901	59.00
60.00 06000	LABORATORY	5,862	81,442	1,266,533	0	2,844,020	60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	929	29,277	660,807	0	1,018,949	65.00
66.00 06600	PHYSICAL THERAPY	8,000	20,124	1,307,217	0	2,254,645	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	340,769	0	474,783	67.00
69.00 06900	ELECTROCARDIOLOGY	5,020	56,340	498,125	0	857,984	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	683	7,440	128,805	0	192,334	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	2,570	0	0	0	7,788,232	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	5,849,407	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,756	37,686	0	0	4,171,604	73.00
74.00 07400	RENAL DIALYSIS	447	0	0	0	34,380	74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01 03650	VASCULAR LAB	381	58,490	210,646	0	353,857	76.01
76.03 03950	WOUND CARE	3,457	7,900	453,162	0	1,172,393	76.03
76.97 07697	CARDIAC REHABILITATION	660	58,778	82,116	0	155,140	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	971	846	129,301	0	225,321	90.00
91.00 09100	EMERGENCY	9,881	139,032	1,900,174	0	3,115,584	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	3,990	167,059	6,249,609	0	10,159,829	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
116.00 11600	HOSPICE	912	238	1,128,338	0	2,233,131	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	321,711	5,729,063	42,598,571	-29,599,935	84,189,647	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	553	622	0	0	26,078	190.00
194.00 07950	PHILANTHROPY DEVELOPMENT	2,538	125,353	85,132	0	3,745,546	194.00
194.02 07952	MEALS ON WHEELS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,200,768	3,731,820	15,272,343		29,599,935	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.775722	0.637369	0.357803		0.336511	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			5,305		3,496,573	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000124	5A	0.039751	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Description		MAINTENANCE & REPAIRS (MAINT. HOURS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	12,078					6.00
7.00	00700	3,137	172,509				7.00
8.00	00800	85	1,633	773,356			8.00
9.00	00900	0	0	0	25,435		9.00
10.00	01000	364	7,024	5,721	1,042	61,706	10.00
11.00	01100	84	1,612	0	240	0	11.00
13.00	01300	76	1,464	0	218	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	110	2,120	0	316	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,152	41,525	244,467	6,181	54,554	30.00
31.00	03100	228	4,403	38,576	655	7,152	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,594	30,751	196,571	4,577	0	50.00
52.00	05200	232	4,468	54,894	665	0	52.00
53.00	05300	10	196	0	29	0	53.00
54.00	05400	799	15,428	27,303	2,296	0	54.00
54.01	03630	28	548	4,118	82	0	54.01
54.02	03450	116	2,231	2,596	332	0	54.02
54.06	05404	10	200	0	30	0	54.06
57.00	05700	73	1,401	8,872	209	0	57.00
58.00	05800	261	5,043	20,037	751	0	58.00
59.00	05900	96	1,852	217	276	0	59.00
60.00	06000	304	5,862	66	873	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	48	929	12,880	138	0	65.00
66.00	06600	415	8,000	8,193	1,191	0	66.00
67.00	06700	0	0	2,359	0	0	67.00
69.00	06900	260	5,020	4,016	747	0	69.00
70.00	07000	35	683	80	102	0	70.00
71.00	07100	133	2,570	0	383	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	195	3,756	0	559	0	73.00
74.00	07400	23	447	0	67	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03650	20	381	2,216	57	0	76.01
76.03	03950	179	3,457	6,893	515	0	76.03
76.97	07697	34	660	825	98	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	50	971	1,579	145	0	90.00
91.00	09100	512	9,881	128,948	1,471	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	207	3,990	0	594	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	47	912	566	136	0	116.00
118.00		11,917	169,418	771,993	24,975	61,706	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	29	553	0	82	0	190.00
194.00	07950	132	2,538	1,363	378	0	194.00
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		20,995	5,947,391	733,074	1,522,012	1,105,879	202.00
203.00		1.738284	34.475830	0.947913	59.839277	17.921742	203.00
204.00		9,467	1,901,877	50,887	46,687	165,770	204.00
205.00		0.783822	11.024799	0.065800	1.835542	2.686449	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	56,642					11.00
13.00	01300	1,090	675,237				13.00
14.00	01400	0	0	14,543,886			14.00
15.00	01500	0	0	0	3,854,791		15.00
16.00	01600	3,762	0	160	0	10,000	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,722	204,751	158,667	16,657	8,865	30.00
31.00	03100	1,874	35,468	31,309	3,226	1,135	31.00
43.00	04300	544	0	16,792	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,590	121,374	9,553,521	20,757	0	50.00
52.00	05200	1,531	0	67,889	0	0	52.00
53.00	05300	1,024	0	44,941	39,751	0	53.00
54.00	05400	2,750	0	157,235	6,502	0	54.00
54.01	03630	245	0	30,967	0	0	54.01
54.02	03450	295	0	243,412	7,976	0	54.02
54.06	05404	0	0	0	0	0	54.06
57.00	05700	518	0	77,924	0	0	57.00
58.00	05800	335	0	40,964	537	0	58.00
59.00	05900	565	0	659,525	745	0	59.00
60.00	06000	2,666	0	1,126,285	702	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	1,368	0	79,323	12	0	65.00
66.00	06600	2,167	0	16,756	44	0	66.00
67.00	06700	489	0	24,338	0	0	67.00
69.00	06900	799	0	18,815	1,086	0	69.00
70.00	07000	211	0	13,264	0	0	70.00
71.00	07100	32	0	1,373,429	437	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1,420	0	274,299	3,572,893	0	73.00
74.00	07400	0	0	131	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03650	274	0	6,367	0	0	76.01
76.03	03950	750	0	77,369	6,772	0	76.03
76.97	07697	108	0	2,252	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	198	0	5,760	0	0	90.00
91.00	09100	3,916	76,525	87,884	7,990	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	10,316	198,917	304,337	5,038	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	1,982	38,202	49,971	163,666	0	116.00
118.00		56,541	675,237	14,543,886	3,854,791	10,000	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	101	0	0	0	0	194.00
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		1,420,684	1,895,602	51,384	2,749,981	6,403,034	202.00
203.00		25.081812	2.807314	0.003533	0.713393	640.303400	203.00
204.00		69,434	82,984	1,531	341,638	257,932	204.00
205.00		1.225839	0.122896	0.000105	0.088627	25.793200	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet B-1 Date/Time Prepared: 11/28/2017 4:13 pm
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Cost Center Description		SOCIAL SERVICE (TIME SPENT) 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
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	54.02
54.06	05404	PET SCAN	54.06
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	76.00
76.01	03650	VASCULAR LAB	76.01
76.03	03950	WOUND CARE	76.03
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	194.00
194.02	07952	MEALS ON WHEELS	194.02
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 4:13 pm
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Dissallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		19,441,726	0	19,441,726
31.00	03100 INTENSIVE CARE UNIT		3,763,562	0	3,763,562
43.00	04300 NURSERY		689,850	0	689,850
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		12,049,084	0	12,049,084
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,290,002	0	2,290,002
53.00	05300 ANESTHESIOLOGY		1,161,132	0	1,161,132
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,669,736	0	4,669,736
54.01	03630 ULTRA SOUND		491,550	0	491,550
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC		856,991	0	856,991
54.06	05404 PET SCAN		171,527	0	171,527
57.00	05700 CT SCAN		1,036,826	0	1,036,826
58.00	05800 MRI		960,501	0	960,501
59.00	05900 CARDIAC CATHETERIZATION		991,764	0	991,764
60.00	06000 LABORATORY		4,127,340	0	4,127,340
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.		0	0	0
65.00	06500 RESPIRATORY THERAPY	0	1,449,016	0	1,449,016
66.00	06600 PHYSICAL THERAPY	0	3,423,363	0	3,423,363
67.00	06700 OCCUPATIONAL THERAPY	0	649,140	0	649,140
69.00	06900 ELECTROCARDIOLOGY		1,389,614	0	1,389,614
70.00	07000 ELECTROENCEPHALOGRAPHY		292,184	0	292,184
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		10,526,777	0	10,526,777
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		7,817,797	0	7,817,797
73.00	07300 DRUGS CHARGED TO PATIENTS		8,324,138	0	8,324,138
74.00	07400 RENAL DIALYSIS		65,409	0	65,409
76.00	03050 BACTERIOLOGY & MICROBIOLOGY		0	0	0
76.01	03650 VASCULAR LAB		498,510	0	498,510
76.03	03950 WOUND CARE		1,747,676	0	1,747,676
76.97	07697 CARDIAC REHABILITATION		239,522	0	239,522
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		349,867	0	349,867
91.00	09100 EMERGENCY		5,034,873	0	5,034,873
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,202,796	0	2,202,796
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY		14,574,022		14,574,022
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
116.00	11600 HOSPICE		3,298,695		3,298,695
200.00	Subtotal (see instructions)		114,584,990	0	114,584,990
201.00	Less Observation Beds		2,202,796	0	2,202,796
202.00	Total (see instructions)		112,382,194	0	112,382,194

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/28/2017 4:13 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	12,650,367		12,650,367				30.00
31.00	03100	INTENSIVE CARE UNIT	2,959,160		2,959,160				31.00
43.00	04300	NURSERY	1,249,080		1,249,080				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	9,866,919	37,469,108	47,336,027	0.254544	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,046,921	552,253	3,599,174	0.636258	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	2,514,492	5,112,506	7,626,998	0.152240	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,404,877	14,493,818	16,898,695	0.276337	0.000000		54.00
54.01	03630	ULTRA SOUND	430,468	3,333,786	3,764,254	0.130584	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	536,134	8,881,983	9,418,117	0.090994	0.000000		54.02
54.06	05404	PET SCAN	0	1,155,038	1,155,038	0.148503	0.000000		54.06
57.00	05700	CT SCAN	4,899,815	25,460,818	30,360,633	0.034150	0.000000		57.00
58.00	05800	MRI	884,775	14,362,171	15,246,946	0.062996	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,474,701	7,206,202	8,680,903	0.114247	0.000000		59.00
60.00	06000	LABORATORY	6,570,194	11,674,654	18,244,848	0.226219	0.000000		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	2,194,123	642,919	2,837,042	0.510749	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,430,568	4,266,216	5,696,784	0.600929	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	638,782	1,483,640	2,122,422	0.305849	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	1,927,200	8,482,023	10,409,223	0.133498	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,045	1,610,047	1,626,092	0.179685	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	15,216,974	18,850,526	34,067,500	0.308998	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	19,684,300	5,945,576	25,629,876	0.305027	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,072,920	17,951,707	36,024,627	0.231068	0.000000		73.00
74.00	07400	RENAL DIALYSIS	64,548	6,903	71,451	0.915439	0.000000		74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	0.000000		76.00
76.01	03650	VASCULAR LAB	251,967	2,659,808	2,911,775	0.171205	0.000000		76.01
76.03	03950	WOUND CARE	41,698	6,761,559	6,803,257	0.256888	0.000000		76.03
76.97	07697	CARDIAC REHABILITATION	963	676,034	676,997	0.353801	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	1,010	550,636	551,646	0.634224	0.000000		90.00
91.00	09100	EMERGENCY	3,920,152	18,643,272	22,563,424	0.223143	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	564,260	2,005,430	2,569,690	0.857222	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	10,391,658	10,391,658				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0	5,526,686	5,526,686				116.00
200.00		Subtotal (see instructions)	113,513,413	236,156,977	349,670,390				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	113,513,413	236,156,977	349,670,390				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 4:13 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital PPS
		INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.254544		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.636258		52.00
53.00	05300	ANESTHESIOLOGY	0.152240		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.276337		54.00
54.01	03630	ULTRA SOUND	0.130584		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.090994		54.02
54.06	05404	PET SCAN	0.148503		54.06
57.00	05700	CT SCAN	0.034150		57.00
58.00	05800	MRI	0.062996		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.114247		59.00
60.00	06000	LABORATORY	0.226219		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.510749		65.00
66.00	06600	PHYSICAL THERAPY	0.600929		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.305849		67.00
69.00	06900	ELECTROCARDIOLOGY	0.133498		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179685		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.308998		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.305027		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.231068		73.00
74.00	07400	RENAL DIALYSIS	0.915439		74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000		76.00
76.01	03650	VASCULAR LAB	0.171205		76.01
76.03	03950	WOUND CARE	0.256888		76.03
76.97	07697	CARDIAC REHABILITATION	0.353801		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.634224		90.00
91.00	09100	EMERGENCY	0.223143		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.857222		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet C
Part I
Date/Time Prepared:
11/28/2017 4:13 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Dissallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	19,441,726		19,441,726	0	19,441,726	30.00
31.00	03100 INTENSIVE CARE UNIT	3,763,562		3,763,562	0	3,763,562	31.00
43.00	04300 NURSERY	689,850		689,850	0	689,850	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,049,084		12,049,084	0	12,049,084	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,290,002		2,290,002	0	2,290,002	52.00
53.00	05300 ANESTHESIOLOGY	1,161,132		1,161,132	0	1,161,132	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,669,736		4,669,736	0	4,669,736	54.00
54.01	03630 ULTRA SOUND	491,550		491,550	0	491,550	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	856,991		856,991	0	856,991	54.02
54.06	05404 PET SCAN	171,527		171,527	0	171,527	54.06
57.00	05700 CT SCAN	1,036,826		1,036,826	0	1,036,826	57.00
58.00	05800 MRI	960,501		960,501	0	960,501	58.00
59.00	05900 CARDIAC CATHETERIZATION	991,764		991,764	0	991,764	59.00
60.00	06000 LABORATORY	4,127,340		4,127,340	0	4,127,340	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,449,016	0	1,449,016	0	1,449,016	65.00
66.00	06600 PHYSICAL THERAPY	3,423,363	0	3,423,363	0	3,423,363	66.00
67.00	06700 OCCUPATIONAL THERAPY	649,140	0	649,140	0	649,140	67.00
69.00	06900 ELECTROCARDIOLOGY	1,389,614		1,389,614	0	1,389,614	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	292,184		292,184	0	292,184	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	10,526,777		10,526,777	0	10,526,777	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	7,817,797		7,817,797	0	7,817,797	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,324,138		8,324,138	0	8,324,138	73.00
74.00	07400 RENAL DIALYSIS	65,409		65,409	0	65,409	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0		0	0	0	76.00
76.01	03650 VASCULAR LAB	498,510		498,510	0	498,510	76.01
76.03	03950 WOUND CARE	1,747,676		1,747,676	0	1,747,676	76.03
76.97	07697 CARDIAC REHABILITATION	239,522		239,522	0	239,522	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	349,867		349,867	0	349,867	90.00
91.00	09100 EMERGENCY	5,034,873		5,034,873	0	5,034,873	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,202,796		2,202,796	0	2,202,796	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	14,574,022		14,574,022		14,574,022	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	3,298,695		3,298,695		3,298,695	116.00
200.00	Subtotal (see instructions)	114,584,990	0	114,584,990	0	114,584,990	200.00
201.00	Less Observation Beds	2,202,796		2,202,796		2,202,796	201.00
202.00	Total (see instructions)	112,382,194	0	112,382,194	0	112,382,194	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/28/2017 4:13 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,650,367		12,650,367			30.00
31.00	03100	INTENSIVE CARE UNIT	2,959,160		2,959,160			31.00
43.00	04300	NURSERY	1,249,080		1,249,080			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,866,919	37,469,108	47,336,027	0.254544	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,046,921	552,253	3,599,174	0.636258	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,514,492	5,112,506	7,626,998	0.152240	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,404,877	14,493,818	16,898,695	0.276337	0.000000	54.00
54.01	03630	ULTRA SOUND	430,468	3,333,786	3,764,254	0.130584	0.000000	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	536,134	8,881,983	9,418,117	0.090994	0.000000	54.02
54.06	05404	PET SCAN	0	1,155,038	1,155,038	0.148503	0.000000	54.06
57.00	05700	CT SCAN	4,899,815	25,460,818	30,360,633	0.034150	0.000000	57.00
58.00	05800	MRI	884,775	14,362,171	15,246,946	0.062996	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,474,701	7,206,202	8,680,903	0.114247	0.000000	59.00
60.00	06000	LABORATORY	6,570,194	11,674,654	18,244,848	0.226219	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	2,194,123	642,919	2,837,042	0.510749	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,430,568	4,266,216	5,696,784	0.600929	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	638,782	1,483,640	2,122,422	0.305849	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	1,927,200	8,482,023	10,409,223	0.133498	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,045	1,610,047	1,626,092	0.179685	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	15,216,974	18,850,526	34,067,500	0.308998	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	19,684,300	5,945,576	25,629,876	0.305027	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,072,920	17,951,707	36,024,627	0.231068	0.000000	73.00
74.00	07400	RENAL DIALYSIS	64,548	6,903	71,451	0.915439	0.000000	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	0.000000	76.00
76.01	03650	VASCULAR LAB	251,967	2,659,808	2,911,775	0.171205	0.000000	76.01
76.03	03950	WOUND CARE	41,698	6,761,559	6,803,257	0.256888	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	963	676,034	676,997	0.353801	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,010	550,636	551,646	0.634224	0.000000	90.00
91.00	09100	EMERGENCY	3,920,152	18,643,272	22,563,424	0.223143	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	564,260	2,005,430	2,569,690	0.857222	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	10,391,658	10,391,658			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	5,526,686	5,526,686			116.00
200.00		Subtotal (see instructions)	113,513,413	236,156,977	349,670,390			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	113,513,413	236,156,977	349,670,390			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 4:13 pm
Cost Center Description			PPS Inpatient Ratio 11.00	Title XIX	Hospital Cost
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		54.02
54.06	05404	PET SCAN	0.000000		54.06
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000		76.00
76.01	03650	VASCULAR LAB	0.000000		76.01
76.03	03950	WOUND CARE	0.000000		76.03
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part I Date/Time Prepared: 11/28/2017 4:13 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	1,621,404	0	1,621,404	15,110	107.31	30.00	
31.00	INTENSIVE CARE UNIT	284,934		284,934	1,766	161.34	31.00	
43.00	NURSERY	22,170		22,170	1,685	13.16	43.00	
200.00	Total (Lines 30-199)	1,928,508		1,928,508	18,561		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	8,016	860,197					30.00
31.00	INTENSIVE CARE UNIT	1,227	197,964					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (Lines 30-199)	9,243	1,058,161					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet D
Part II
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		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	1,727,325	47,336,027	0.036491	5,886,971	214,821	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	178,431	3,599,174	0.049576	69,091	3,425	52.00
53.00	05300	ANESTHESIOLOGY	97,265	7,626,998	0.012753	1,289,284	16,442	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	954,307	16,898,695	0.056472	1,896,885	107,121	54.00
54.01	03630	ULTRA SOUND	74,493	3,764,254	0.019790	271,243	5,368	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	67,235	9,418,117	0.007139	426,855	3,047	54.02
54.06	05404	PET SCAN	8,466	1,155,038	0.007330	0	0	54.06
57.00	05700	CT SCAN	60,364	30,360,633	0.001988	3,640,450	7,237	57.00
58.00	05800	MRI	122,122	15,246,946	0.008010	594,268	4,760	58.00
59.00	05900	CARDIAC CATHETERIZATION	92,729	8,680,903	0.010682	860,428	9,191	59.00
60.00	06000	LABORATORY	392,348	18,244,848	0.021505	4,159,366	89,447	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	143,420	2,837,042	0.050553	1,643,936	83,106	65.00
66.00	06600	PHYSICAL THERAPY	393,897	5,696,784	0.069144	998,271	69,024	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,672	2,122,422	0.009269	441,679	4,094	67.00
69.00	06900	ELECTROCARDIOLOGY	162,351	10,409,223	0.015597	1,547,953	24,143	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,018	1,626,092	0.020305	8,654	176	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	356,367	34,067,500	0.010461	8,070,633	84,427	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	232,520	25,629,876	0.009072	10,509,015	95,338	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	835,997	36,024,627	0.023206	11,332,844	262,990	73.00
74.00	07400	RENAL DIALYSIS	9,465	71,451	0.132468	56,142	7,437	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03650	VASCULAR LAB	58,758	2,911,775	0.020179	174,652	3,524	76.01
76.03	03950	WOUND CARE	116,298	6,803,257	0.017094	30,579	523	76.03
76.97	07697	CARDIAC REHABILITATION	55,781	676,997	0.082395	736	61	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	27,449	551,646	0.049758	882	44	90.00
91.00	09100	EMERGENCY	415,094	22,563,424	0.018397	2,686,883	49,431	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	183,709	2,569,690	0.071491	371,625	26,568	92.00
200.00		Total (lines 50-199)	6,818,881	316,893,439		56,969,325	1,171,745	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part III Date/Time Prepared: 11/28/2017 4:13 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,110	0.00	8,016	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,766	0.00	1,227	0		31.00
43.00	04300	NURSERY	1,685	0.00	0	0		43.00
200.00		Total (lines 30-199)	18,561		9,243	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 4:13 pm
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Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	0	54.02
54.06	05404	PET SCAN	0	0	0	0	0	0	54.06
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	0	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 4:13 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	47,336,027	0.000000	0.000000	5,886,971	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,599,174	0.000000	0.000000	69,091	52.00
53.00	05300	ANESTHESIOLOGY	0	7,626,998	0.000000	0.000000	1,289,284	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,898,695	0.000000	0.000000	1,896,885	54.00
54.01	03630	ULTRA SOUND	0	3,764,254	0.000000	0.000000	271,243	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	9,418,117	0.000000	0.000000	426,855	54.02
54.06	05404	PET SCAN	0	1,155,038	0.000000	0.000000	0	54.06
57.00	05700	CT SCAN	0	30,360,633	0.000000	0.000000	3,640,450	57.00
58.00	05800	MRI	0	15,246,946	0.000000	0.000000	594,268	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,680,903	0.000000	0.000000	860,428	59.00
60.00	06000	LABORATORY	0	18,244,848	0.000000	0.000000	4,159,366	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,837,042	0.000000	0.000000	1,643,936	65.00
66.00	06600	PHYSICAL THERAPY	0	5,696,784	0.000000	0.000000	998,271	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,122,422	0.000000	0.000000	441,679	67.00
69.00	06900	ELECTROCARDIOLOGY	0	10,409,223	0.000000	0.000000	1,547,953	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,626,092	0.000000	0.000000	8,654	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	34,067,500	0.000000	0.000000	8,070,633	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	25,629,876	0.000000	0.000000	10,509,015	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	36,024,627	0.000000	0.000000	11,332,844	73.00
74.00	07400	RENAL DIALYSIS	0	71,451	0.000000	0.000000	56,142	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03650	VASCULAR LAB	0	2,911,775	0.000000	0.000000	174,652	76.01
76.03	03950	WOUND CARE	0	6,803,257	0.000000	0.000000	30,579	76.03
76.97	07697	CARDIAC REHABILITATION	0	676,997	0.000000	0.000000	736	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	551,646	0.000000	0.000000	882	90.00
91.00	09100	EMERGENCY	0	22,563,424	0.000000	0.000000	2,686,883	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	2,569,690	0.000000	0.000000	371,625	92.00
200.00		Total (lines 50-199)	0	316,893,439			56,969,325	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 4:13 pm
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	9,471,440	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	299,956	0	52.00
53.00	05300 ANESTHESIOLOGY	0	2,310,315	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,475,494	0	54.00
54.01	03630 ULTRA SOUND	0	1,172,292	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	4,937,979	0	54.02
54.06	05404 PET SCAN	0	378,123	0	54.06
57.00	05700 CT SCAN	0	9,601,891	0	57.00
58.00	05800 MRI	0	5,191,689	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,639,564	0	59.00
60.00	06000 LABORATORY	0	2,499,167	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	323,166	0	65.00
66.00	06600 PHYSICAL THERAPY	0	51,733	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	11,819	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0	4,223,496	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	612,037	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	5,997,692	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	2,401,861	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,307,438	0	73.00
74.00	07400 RENAL DIALYSIS	0	4,407	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	76.00
76.01	03650 VASCULAR LAB	0	1,518,766	0	76.01
76.03	03950 WOUND CARE	0	7,346,914	0	76.03
76.97	07697 CARDIAC REHABILITATION	0	370,783	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	48,384	0	90.00
91.00	09100 EMERGENCY	0	5,290,794	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	953,327	0	92.00
200.00	Total (lines 50-199)	0	79,440,527	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 4:13 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.254544	9,471,440	0	77,472	2,410,898	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.636258	299,956	0	0	190,849	52.00
53.00	05300 ANESTHESIOLOGY	0.152240	2,310,315	0	0	351,722	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.276337	4,475,494	0	0	1,236,745	54.00
54.01	03630 ULTRA SOUND	0.130584	1,172,292	0	0	153,083	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.090994	4,937,979	0	0	449,326	54.02
54.06	05404 PET SCAN	0.148503	378,123	0	0	56,152	54.06
57.00	05700 CT SCAN	0.034150	9,601,891	0	0	327,905	57.00
58.00	05800 MRI	0.062996	5,191,689	0	0	327,056	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.114247	2,639,564	0	0	301,562	59.00
60.00	06000 LABORATORY	0.226219	2,499,167	1,892	0	565,359	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.510749	323,166	257	0	165,057	65.00
66.00	06600 PHYSICAL THERAPY	0.600929	51,733	0	3	31,088	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.305849	11,819	0	152	3,615	67.00
69.00	06900 ELECTROCARDIOLOGY	0.133498	4,223,496	0	0	563,828	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.179685	612,037	0	0	109,974	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.308998	5,997,692	0	0	1,853,275	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.305027	2,401,861	0	0	732,632	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.231068	7,307,438	0	0	1,688,515	73.00
74.00	07400 RENAL DIALYSIS	0.915439	4,407	0	0	4,034	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01	03650 VASCULAR LAB	0.171205	1,518,766	0	0	260,020	76.01
76.03	03950 WOUND CARE	0.256888	7,346,914	0	0	1,887,334	76.03
76.97	07697 CARDIAC REHABILITATION	0.353801	370,783	0	0	131,183	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.634224	48,384	0	0	30,686	90.00
91.00	09100 EMERGENCY	0.223143	5,290,794	0	0	1,180,604	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.857222	953,327	0	0	817,213	92.00
200.00	Subtotal (see instructions)		79,440,527	2,149	77,627	15,829,715	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		79,440,527	2,149	77,627	15,829,715	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 4:13 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	19,720		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03630 ULTRA SOUND	0	0		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.02
54.06 05404 PET SCAN	0	0		54.06
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	428	0		60.00
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	131	0		65.00
66.00 06600 PHYSICAL THERAPY	0	2		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	46		67.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0	0		76.00
76.01 03650 VASCULAR LAB	0	0		76.01
76.03 03950 WOUND CARE	0	0		76.03
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00 Subtotal (see instructions)	559	19,768		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	559	19,768		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 4:13 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,110	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,110	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)		13,398	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)		8,016	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)		19,441,726	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)		19,441,726	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)		19,441,726	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)		1,286.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,314,027	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)		10,314,027	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,763,562	1,766	2,131.12	1,227	2,614,884	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)					14,647,076	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					27,575,987	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,058,161	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,171,745	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,229,906	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					25,346,081	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)					1,712	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,286.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,202,796	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0032		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 4:13 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,621,404	19,441,726	0.083398	2,202,796	183,709	90.00
91.00	Nursing School cost	0	19,441,726	0.000000	2,202,796	0	91.00
92.00	Allied health cost	0	19,441,726	0.000000	2,202,796	0	92.00
93.00	All other Medical Education	0	19,441,726	0.000000	2,202,796	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3	
		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		7,031,244	30.00
31.00	03100	INTENSIVE CARE UNIT		2,089,124	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.254544	5,886,971	1,498,493 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.636258	69,091	43,960 52.00
53.00	05300	ANESTHESIOLOGY	0.152240	1,289,284	196,281 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.276337	1,896,885	524,180 54.00
54.01	03630	ULTRA SOUND	0.130584	271,243	35,420 54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.090994	426,855	38,841 54.02
54.06	05404	PET SCAN	0.148503	0	0 54.06
57.00	05700	CT SCAN	0.034150	3,640,450	124,321 57.00
58.00	05800	MRI	0.062996	594,268	37,437 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.114247	860,428	98,301 59.00
60.00	06000	LABORATORY	0.226219	4,159,366	940,928 60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.510749	1,643,936	839,639 65.00
66.00	06600	PHYSICAL THERAPY	0.600929	998,271	599,890 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.305849	441,679	135,087 67.00
69.00	06900	ELECTROCARDIOLOGY	0.133498	1,547,953	206,649 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179685	8,654	1,555 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.308998	8,070,633	2,493,809 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.305027	10,509,015	3,205,533 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.231068	11,332,844	2,618,658 73.00
74.00	07400	RENAL DIALYSIS	0.915439	56,142	51,395 74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0 76.00
76.01	03650	VASCULAR LAB	0.171205	174,652	29,901 76.01
76.03	03950	WOUND CARE	0.256888	30,579	7,855 76.03
76.97	07697	CARDIAC REHABILITATION	0.353801	736	260 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.634224	882	559 90.00
91.00	09100	EMERGENCY	0.223143	2,686,883	599,559 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.857222	371,625	318,565 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		56,969,325	14,647,076 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		56,969,325	14,647,076 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 4:13 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		4,845,565	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		14,378,686	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		249,889	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		345,943	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		128.11	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.06	30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.27	31.00
32.00	Sum of lines 30 and 31		20.33	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.99	33.00
34.00	Disproportionate share adjustment (see instructions)		287,883	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 4:13 pm	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00	
35.01	Factor 3 (see instructions)	0.000091632	0.000093481	35.01	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	587,007	558,782	35.02	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	147,554	417,938	35.03	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	565,492		36.00	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00	
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00	
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00	
47.00	Subtotal (see instructions)	20,327,515		47.00	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00	
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)		20,327,515	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,575,402	50.00	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00	
53.00	Nursing and Allied Health Managed Care payment		0	53.00	
54.00	Special add-on payments for new technologies		0	54.00	
54.01	Islet isolation add-on payment		0	54.01	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00	
59.00	Total (sum of amounts on lines 49 through 58)		21,902,917	59.00	
60.00	Primary payer payments		0	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		21,902,917	61.00	
62.00	Deductibles billed to program beneficiaries		2,514,708	62.00	
63.00	Coinurance billed to program beneficiaries		10,983	63.00	
64.00	Allowable bad debts (see instructions)		312,245	64.00	
65.00	Adjusted reimbursable bad debts (see instructions)		202,959	65.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		156,806	66.00	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		19,580,185	67.00	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00	
70.50	RURAL DEMONSTRATION PROJECT		0	70.50	
70.88	SCH or MDH volume decrease adjustment		0	70.88	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91	
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92	
70.93	HVBP payment adjustment amount (see instructions)		101,254	70.93	
70.94	HRR adjustment amount (see instructions)		-25,733	70.94	
70.95	Recovery of accelerated depreciation		0	70.95	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 4:13 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			19,655,706	71.00
71.01	Sequestration adjustment (see instructions)			393,114	71.01
72.00	Interim payments			19,315,804	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			-53,212	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			179,440	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/28/2017 4:13 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		20,327	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,829,715	2.00
3.00	PPS payments		14,593,333	3.00
4.00	Outlier payment (see instructions)		38,098	4.00
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 line 3 plus line 4 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)		20,327	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		79,776	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)		79,776	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 charge basis 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)		79,776	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		59,449	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 (line 11 minus line 20) (for CAH see instructions)		20,327	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, 8 and 9)		14,631,431	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		116,659	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,906,194	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)		11,628,905	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)		11,628,905	30.00
31.00	Primary payer payments		226	31.00
32.00	Subtotal (line 30 minus line 31)		11,628,679	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)		285,540	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		185,601	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		96,638	36.00
37.00	Subtotal (see instructions)		11,814,280	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)		0	39.50
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)		11,814,280	40.00
40.01	Sequestration adjustment (see instructions)		236,286	40.01
41.00	Interim payments		11,804,940	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-226,946	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: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2017 4:13 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		19,293,895		11,742,983	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	01/26/2017	21,909	01/26/2017	61,957	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		21,909		61,957	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)		19,315,804		11,804,940	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		53,212		226,946	6.02	
7.00	Total Medicare program liability (see instructions)		19,262,592		11,577,994	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet E-1
Part II
Date/Time Prepared:
11/28/2017 4:13 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			5,125 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			9,243 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			174 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			15,164 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			349,670,390 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			10,499,181 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

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

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet G
Date/Time Prepared:
11/28/2017 4:13 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	18,083,647	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	83,779,194	0	0	0	4.00
5.00	Other receivable	1,000,592	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-55,026,919	0	0	0	6.00
7.00	Inventory	4,539,938	0	0	0	7.00
8.00	Prepaid expenses	240,473	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	503,814	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	53,120,739	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,699,574	0	0	0	12.00
13.00	Land improvements	360,444	0	0	0	13.00
14.00	Accumulated depreciation	-2,158,513	0	0	0	14.00
15.00	Buildings	68,790,165	0	0	0	15.00
16.00	Accumulated depreciation	-31,653,301	0	0	0	16.00
17.00	Leasehold improvements	70,645	0	0	0	17.00
18.00	Accumulated depreciation	-66,270	0	0	0	18.00
19.00	Fixed equipment	15,074,960	0	0	0	19.00
20.00	Accumulated depreciation	-14,103,995	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	71,945,284	0	0	0	23.00
24.00	Accumulated depreciation	-60,872,645	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	3,501,466	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	53,587,814	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	323,230,592	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	10,807,559	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	334,038,151	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	440,746,704	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,104,931	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,152,067	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,776,236	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	12,779,246	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	27,812,480	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,062,395	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	17,205,245	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	34,267,640	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	62,080,120	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	378,666,584				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)	378,666,584	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	440,746,704	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-1

Date/Time Prepared:
11/28/2017 4:13 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		339,060,538		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		37,936,167			2.00
3.00	Total (sum of line 1 and line 2)		376,996,705		0	3.00
4.00	TEMPORARILY RESTRICTED	1,491,745		0		4.00
5.00	PERMANENTLY RESTRICTED	178,134		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1,669,879		0	10.00
11.00	Subtotal (line 3 plus line 10)		378,666,584		0	11.00
12.00		0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		378,666,584		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	TEMPORARILY RESTRICTED		0			4.00
5.00	PERMANENTLY RESTRICTED		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			0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	14,313,776		14,313,776	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				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)	14,313,776		14,313,776	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,024,039		3,024,039	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)	3,024,039		3,024,039	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,337,815		17,337,815	17.00
18.00	Ancillary services	94,100,717	208,418,124	302,518,841	18.00
19.00	Outpatient services	3,957,636	19,532,604	23,490,240	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		10,391,658	10,391,658	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	5,526,686	5,526,686	26.00
27.00	PROFESSIONAL FEES	0	2,537,002	2,537,002	27.00
27.01	OTHER NONREIMBURSABLE COST CENTERS	0	4,996,927	4,996,927	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	115,396,168	251,403,001	366,799,169	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		125,491,527		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)		125,491,527		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0032

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-3

Date/Time Prepared:
11/28/2017 4:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	366,799,169	1.00
2.00	Less contractual allowances and discounts on patients' accounts	228,708,425	2.00
3.00	Net patient revenues (line 1 minus line 2)	138,090,744	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	125,491,527	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,599,217	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	19,783,578	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	2,970,880	24.00
24.01	NON-OPERATING REVENUE	1,933,156	24.01
24.02	INVESTMENT INCOME ADJ	649,336	24.02
25.00	Total other income (sum of lines 6-24)	25,336,950	25.00
26.00	Total (line 5 plus line 25)	37,936,167	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	37,936,167	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet H
		HHA CCN: 14-7661		Date/Time Prepared: 11/28/2017 4:13 pm
			Home Health Agency I	PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	356,038	356,038	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	933,397	0	4,212	0	487,130	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	3,934,879	0	269,049	0	4,203,928	6.00
7.00	Physical Therapy	599,666	0	57,240	303,358	960,264	7.00
8.00	Occupational Therapy	358,218	0	26,042	0	384,260	8.00
9.00	Speech Pathology	67,884	0	4,947	0	72,831	9.00
10.00	Medical Social Services	94,282	0	6,754	0	101,036	10.00
11.00	Home Health Aide	261,283	0	19,018	0	280,301	11.00
12.00	Supplies (see instructions)	0	0	0	318,568	318,568	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	6,249,609	0	387,262	303,358	1,161,736	24.00
	Reclassified	Reclassified	Adjustments	Net Expenses			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	356,038	0	356,038		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	1,424,739	-2,387	1,422,352		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	4,203,928	0	4,203,928		6.00
7.00	Physical Therapy	0	960,264	0	960,264		7.00
8.00	Occupational Therapy	0	384,260	0	384,260		8.00
9.00	Speech Pathology	0	72,831	0	72,831		9.00
10.00	Medical Social Services	0	101,036	0	101,036		10.00
11.00	Home Health Aide	0	280,301	0	280,301		11.00
12.00	Supplies (see instructions)	-309,375	9,193	0	9,193		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-309,375	7,792,590	-2,387	7,790,203		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet H-1 Part I Date/Time Prepared: 11/28/2017 4:13 pm
		HHA CCN: 14-7661	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0		0		0	2.00
3.00	Plant Operation & Maintenance	356,038	0	0	356,038	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	1,422,352	0	0	356,038	0	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	4,203,928	0	0	0	0	6.00
7.00	Physical Therapy	960,264	0	0	0	0	7.00
8.00	Occupational Therapy	384,260	0	0	0	0	8.00
9.00	Speech Pathology	72,831	0	0	0	0	9.00
10.00	Medical Social Services	101,036	0	0	0	0	10.00
11.00	Home Health Aide	280,301	0	0	0	0	11.00
12.00	Supplies (see instructions)	9,193	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	7,790,203	0	0	356,038	0	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	1,778,390					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,243,589	5,447,517				6.00
7.00	Physical Therapy	284,061	1,244,325				7.00
8.00	Occupational Therapy	113,670	497,930				8.00
9.00	Speech Pathology	21,545	94,376				9.00
10.00	Medical Social Services	29,888	130,924				10.00
11.00	Home Health Aide	82,918	363,219				11.00
12.00	Supplies (see instructions)	2,719	11,912				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		7,790,203				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet H-1

HHA CCN: 14-7661

To 06/30/2017

Part II
Date/Time Prepared:
11/28/2017 4:13 pm

Home Health Agency I

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)		
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)						
	1.00	2.00						3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	3,990			0		1.00	
2.00	Capital Related - Movable Equipment		167,059		0		2.00	
3.00	Plant Operation & Maintenance	0	0	3,990	0		3.00	
4.00	Transportation (see instructions)	0	0	0	0		4.00	
5.00	Administrative and General	3,990	167,059	3,990	0	-1,778,390	6,011,813	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	0	4,203,928	6.00
7.00	Physical Therapy	0	0	0	0	0	960,264	7.00
8.00	Occupational Therapy	0	0	0	0	0	384,260	8.00
9.00	Speech Pathology	0	0	0	0	0	72,831	9.00
10.00	Medical Social Services	0	0	0	0	0	101,036	10.00
11.00	Home Health Aide	0	0	0	0	0	280,301	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	9,193	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,990	167,059	3,990	0	-1,778,390	6,011,813	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	356,038	0		1,778,390	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	89.232581	0.000000		0.295816	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet H-2

HHA CCN: 14-7661

To 06/30/2017

Part I
Date/Time Prepared:
11/28/2017 4:13 pm

Home Health
Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	27,035	106,478	333,969	467,482	157,313	1.00
2.00 Skilled Nursing Care	5,447,517	0	0	1,407,904	6,855,421	2,306,920	2.00
3.00 Physical Therapy	1,244,325	0	0	214,560	1,458,885	490,931	3.00
4.00 Occupational Therapy	497,930	0	0	128,170	626,100	210,690	4.00
5.00 Speech Pathology	94,376	0	0	24,289	118,665	39,932	5.00
6.00 Medical Social Services	130,924	0	0	33,734	164,658	55,409	6.00
7.00 Home Health Aide	363,219	0	0	93,487	456,706	153,687	7.00
8.00 Supplies (see instructions)	11,912	0	0	0	11,912	4,009	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	7,790,203	27,035	106,478	2,236,113	10,159,829	3,418,891	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	6.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	360	137,559	0	35,545	0	258,747	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	360	137,559	0	35,545	0	258,747	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet H-2

HHA CCN: 14-7661

To 06/30/2017

Part I
Date/Time Prepared:
11/28/2017 4:13 pm

Home Health Agency I

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Cost Center Description		NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	Subtotal	
		ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY			
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	558,422	1,075	3,594		0	1,620,097	1.00
2.00	Skilled Nursing Care	0	0	0		0	9,162,341	2.00
3.00	Physical Therapy	0	0	0		0	1,949,816	3.00
4.00	Occupational Therapy	0	0	0		0	836,790	4.00
5.00	Speech Pathology	0	0	0		0	158,597	5.00
6.00	Medical Social Services	0	0	0		0	220,067	6.00
7.00	Home Health Aide	0	0	0		0	610,393	7.00
8.00	Supplies (see instructions)	0	0	0		0	15,921	8.00
9.00	Drugs	0	0	0		0	0	9.00
10.00	DME	0	0	0		0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0		0	0	11.00
12.00	Respiratory Therapy	0	0	0		0	0	12.00
13.00	Private Duty Nursing	0	0	0		0	0	13.00
14.00	Clinic	0	0	0		0	0	14.00
15.00	Health Promotion Activities	0	0	0		0	0	15.00
16.00	Day Care Program	0	0	0		0	0	16.00
17.00	Home Delivered Meals Program	0	0	0		0	0	17.00
18.00	Homemaker Service	0	0	0		0	0	18.00
19.00	All Others (specify)	0	0	0		0	0	19.00
19.50	Telemedicine	0	0	0		0	0	19.50
20.00	Total (sum of lines 1-19) (2)	558,422	1,075	3,594		0	14,574,022	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	1,620,097					1.00
2.00	Skilled Nursing Care	0	9,162,341	1,145,899	10,308,240			2.00
3.00	Physical Therapy	0	1,949,816	243,856	2,193,672			3.00
4.00	Occupational Therapy	0	836,790	104,654	941,444			4.00
5.00	Speech Pathology	0	158,597	19,835	178,432			5.00
6.00	Medical Social Services	0	220,067	27,523	247,590			6.00
7.00	Home Health Aide	0	610,393	76,339	686,732			7.00
8.00	Supplies (see instructions)	0	15,921	1,991	17,912			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	14,574,022	1,620,097	14,574,022			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.125066				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0032
HHA CCN: 14-7661

Period: From 07/01/2016 To 06/30/2017

Worksheet H-2 Part II
Date/Time Prepared: 11/28/2017 4:13 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (MAINT. HOURS)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	3,990	167,059	933,397	0	467,482	207	1.00
2.00 Skilled Nursing Care	0	0	3,934,879	0	6,855,421	0	2.00
3.00 Physical Therapy	0	0	599,666	0	1,458,885	0	3.00
4.00 Occupational Therapy	0	0	358,218	0	626,100	0	4.00
5.00 Speech Pathology	0	0	67,884	0	118,665	0	5.00
6.00 Medical Social Services	0	0	94,282	0	164,658	0	6.00
7.00 Home Health Aide	0	0	261,283	0	456,706	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	11,912	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	3,990	167,059	6,249,609		10,159,829	207	20.00
21.00 Total cost to be allocated	27,035	106,478	2,236,113		3,418,891	360	21.00
22.00 Unit cost multiplier	6.775689	0.637368	0.357800		0.336511	1.739130	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	3,990	0	594	0	10,316	198,917	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	3,990	0	594	0	10,316	198,917	20.00
21.00 Total cost to be allocated	137,559	0	35,545	0	258,747	558,422	21.00
22.00 Unit cost multiplier	34.475940	0.000000	59.840067	0.000000	25.082105	2.807312	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0032
HHA CCN: 14-7661

Period: From 07/01/2016 To 06/30/2017

Worksheet H-2 Part II
Date/Time Prepared: 11/28/2017 4:13 pm

Home Health Agency I

PPS

Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
	14.00	15.00	16.00	17.00		
1.00 Administrative and General	304,337	5,038	0	0		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
19.50 Telemedicine	0	0	0	0		19.50
20.00 Total (sum of lines 1-19)	304,337	5,038	0	0		20.00
21.00 Total cost to be allocated	1,075	3,594	0	0		21.00
22.00 Unit cost multiplier	0.003532	0.713378	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0032 HHA CCN: 14-7661		Period: From 07/01/2016 To 06/30/2017		Worksheet H-3 Part I Date/Time Prepared: 11/28/2017 4:13 pm	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	2.00	10,308,240		10,308,240	37,097	277.87		1.00
2.00	Physical Therapy	3.00	2,193,672	0	2,193,672	13,042	168.20		2.00
3.00	Occupational Therapy	4.00	941,444	0	941,444	4,030	233.61		3.00
4.00	Speech Pathology	5.00	178,432	0	178,432	835	213.69		4.00
5.00	Medical Social Services	6.00	247,590		247,590	490	505.29		5.00
6.00	Home Health Aide	7.00	686,732		686,732	4,616	148.77		6.00
7.00	Total (sum of lines 1-6)		14,556,110	0	14,556,110	60,110			7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits				
		0	1.00	2.00	Part B				
					Not Subject to Deductibles & Coinsurance		Subject to Deductibles		
		0	1.00	2.00	3.00		4.00		5.00
Limitation Cost Computation									
8.00	Skilled Nursing Care		41180	0	19,278				8.00
9.00	Physical Therapy		41180	0	8,135				9.00
10.00	Occupational Therapy		41180	0	2,536				10.00
11.00	Speech Pathology		41180	0	227				11.00
12.00	Medical Social Services		41180	0	269				12.00
13.00	Home Health Aide		41180	0	3,202				13.00
14.00	Total (sum of lines 8-13)			0	33,647				14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 + col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	8.00	17,912	0	17,912	75,402	0.237553		15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000		16.00
Cost Center Description		Part A	Program Visits		Cost of Services				
			Part B						
			Not Subject to Deductibles & Coinsurance		Part A	Part B			
		6.00	7.00	8.00	9.00	10.00		11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	0	19,278		0	5,356,778			1.00
2.00	Physical Therapy	0	8,135		0	1,368,307			2.00
3.00	Occupational Therapy	0	2,536		0	592,435			3.00
4.00	Speech Pathology	0	227		0	48,508			4.00
5.00	Medical Social Services	0	269		0	135,923			5.00
6.00	Home Health Aide	0	3,202		0	476,362			6.00
7.00	Total (sum of lines 1-6)	0	33,647		0	7,978,313			7.00
Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
9.00	Physical Therapy								9.00
10.00	Occupational Therapy								10.00
11.00	Speech Pathology								11.00
12.00	Medical Social Services								12.00
13.00	Home Health Aide								13.00
14.00	Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0032 HHA CCN: 14-7661		Period: From 07/01/2016 To 06/30/2017		Worksheet H-3 Part I Date/Time Prepared: 11/28/2017 4:13 pm	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description	Program Covered Charges			Cost of Services					
	Part A	Part B			Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	6.00	7.00	8.00	9.00	10.00	11.00			
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description									
		Total Program Cost (sum of col.s. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	5,356,778							1.00
2.00	Physical Therapy	1,368,307							2.00
3.00	Occupational Therapy	592,435							3.00
4.00	Speech Pathology	48,508							4.00
5.00	Medical Social Services	135,923							5.00
6.00	Home Health Aide	476,362							6.00
7.00	Total (sum of lines 1-6)	7,978,313							7.00
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 14-0032 HHA CCN: 14-7661		Period: From 07/01/2016 To 06/30/2017		Worksheet H-3 Part II Date/Time Prepared: 11/28/2017 4:13 pm	
			Title XVIII		Home Health Agency I		PPS	
Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated			
	0	1.00	2.00	3.00	4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS								
1.00	Physical Therapy	66.00	0.600929	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.305849	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.308998	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.231068	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032 HHA CCN: 14-7661	Period: From 07/01/2016 To 06/30/2017	Worksheet H-4 Part I-11 Date/Time Prepared: 11/28/2017 4:13 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	4,566,712
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	394,471
13.00	Total PPS Reimbursement - LUPA Episodes		0	62,284
14.00	Total PPS Reimbursement - PEP Episodes		0	29,337
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	136,037
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	11,418
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	5,200,259
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	5,200,259
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	5,200,259
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	5,200,259
30.00	OTHER PSR ADJUSTMENT		0	-2,964
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	5,197,295
31.01	Sequestration adjustment (see instructions)		0	103,946
32.00	Interim payments (see instructions)		0	5,093,349
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-0032
HHA CCN: 14-7661

Period: From 07/01/2016 To 06/30/2017

Worksheet H-5
Date/Time Prepared: 11/28/2017 4:13 pm
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		0		5,093,349	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			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			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		5,093,349	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		5,093,349	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet 0

Hospice CCN: 14-1658

To 06/30/2017

Date/Time Prepared: 11/28/2017 4:13 pm

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0
2.00	CAP REL COSTS-MVBLE EQUIP*		20,867	20,867	0	20,867
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0
4.00	ADMINISTRATIVE & GENERAL*	267,556	75,433	342,989	-213,637	129,352
5.00	PLANT OPERATION & MAINTENANCE*	0	2,675	2,675	0	2,675
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	32	32	0	32
11.00	MEDICAL RECORDS*	0	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0
14.00	PHARMACY*	0	163,666	163,666	0	163,666
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	412,718	412,718	0	412,718
26.00	PHYSICIAN SERVICES**	0	14,688	14,688	0	14,688
27.00	NURSE PRACTITIONER**	8,899	1,239	10,138	0	10,138
28.00	REGISTERED NURSE**	684,376	95,290	779,666	0	779,666
29.00	LPN/LVN**	0	0	0	0	0
30.00	PHYSICAL THERAPY**	0	0	0	0	0
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	66,242	9,223	75,465	0	75,465
34.00	SPIRITUAL COUNSELING**	28,786	4,008	32,794	0	32,794
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	60,808	8,466	69,274	0	69,274
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	48,507	48,507	0	48,507
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	49,939	49,939	0	49,939
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	11,671	1,625	13,296	0	13,296
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0
100.00	TOTAL	1,128,338	908,376	2,036,714	-213,637	1,823,077

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet 0

Hospice CCN: 14-1658

To 06/30/2017

Date/Time Prepared: 11/28/2017 4:13 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	20,867	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	129,352	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	2,675	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	32	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	163,666	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	412,718	25.00
26.00	PHYSICIAN SERVICES**	0	14,688	26.00
27.00	NURSE PRACTITIONER**	0	10,138	27.00
28.00	REGISTERED NURSE**	0	779,666	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	75,465	33.00
34.00	SPIRITUAL COUNSELING**	0	32,794	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	69,274	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	48,507	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	49,939	42.00
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	13,296	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	1,823,077	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPI CE COSTS FOR HOSPI CE ROUTINE HOME CARE

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet 0-2

Hospice CCN: 14-1658

To 06/30/2017

Date/Time Prepared: 11/28/2017 4:13 pm

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED					25.00
26.00	PHYSICIAN SERVICES	0	14,427	14,427	0	26.00
27.00	NURSE PRACTITIONER	8,736	1,217	9,953	0	27.00
28.00	REGISTERED NURSE	671,797	93,597	765,394	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	65,024	9,059	74,083	0	33.00
34.00	SPIRITUAL COUNSELING	28,257	3,937	32,194	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPI CE AI DE & HOME MAKER SERVICES	59,690	8,316	68,006	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	48,507	48,507	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	49,052	49,052	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	11,457	1,596	13,053	0	46.00
100.00	TOTAL *	844,961	229,708	1,074,669	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)
		6.00	7.00
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED		25.00
26.00	PHYSICIAN SERVICES	0	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	0	28.00
29.00	LPN/LVN	0	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	33.00
34.00	SPIRITUAL COUNSELING	0	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPI CE AI DE & HOME MAKER SERVICES	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	42.00
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPIRE CARE

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet 0-3

Hospice CCN: 14-1658

To 06/30/2017

Date/Time Prepared: 11/28/2017 4:13 pm

		Hospice I				
		SALARIES	OTHER	RECLASSIFI -	SUBTOTAL	
		1.00	2.00	CATIONS	5.00	
		SUBTOTAL (col .		4.00		
		1 + col . 2)				
		3.00				
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	39,218	0	39,218	25.00
26.00	PHYSICIAN SERVICES	0	25	0	25	26.00
27.00	NURSE PRACTITIONER	150	2	0	152	27.00
28.00	REGISTERED NURSE	11,558	161	0	11,719	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	1,119	16	0	1,135	33.00
34.00	SPIRITUAL COUNSELING	486	7	0	493	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	1,027	14	0	1,041	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN					38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	84	0	84	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	197	3	0	200	46.00
100.00	TOTAL *	14,537	39,530	0	54,067	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col . 5		
		6.00	± col . 6)		
		7.00			
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED	0	39,218		25.00
26.00	PHYSICIAN SERVICES	0	25		26.00
27.00	NURSE PRACTITIONER	0	152		27.00
28.00	REGISTERED NURSE	0	11,719		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	1,135		33.00
34.00	SPIRITUAL COUNSELING	0	493		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	1,041		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	84		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	200		46.00
100.00	TOTAL *	0	54,067		100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE	Provider CCN: 14-0032 Hospice CCN: 14-1658	Period: From 07/01/2016 To 06/30/2017	Worksheet 0-4 Date/Time Prepared: 11/28/2017 4:13 pm
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		SALARIES	OTHER	SUBTOTAL (col . 1 + col . 2)	Hospice I RECLASSIFI - CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED	0	373,500	373,500	0	373,500	25.00
26.00	PHYSICIAN SERVICES	0	236	236	0	236	26.00
27.00	NURSE PRACTITIONER	13	20	33	0	33	27.00
28.00	REGISTERED NURSE	1,021	1,532	2,553	0	2,553	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	99	148	247	0	247	33.00
34.00	SPIRITUAL COUNSELING	43	64	107	0	107	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	91	136	227	0	227	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	803	803	0	803	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	17	26	43	0	43	46.00
100.00	TOTAL *	1,284	376,465	377,749	0	377,749	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col . 5 ± col . 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	373,500	25.00
26.00	PHYSICIAN SERVICES	0	236	26.00
27.00	NURSE PRACTITIONER	0	33	27.00
28.00	REGISTERED NURSE	0	2,553	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	247	33.00
34.00	SPIRITUAL COUNSELING	0	107	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	227	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	803	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	43	46.00
100.00	TOTAL *	0	377,749	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet 0-5

Hospice CCN: 14-1658

To 06/30/2017

Date/Time Prepared: 11/28/2017 4:13 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	6,179	6,179	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,867	152	21,019	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	403,723	403,723	3.00
4.00	ADMINISTRATIVE & GENERAL	129,352	801,185	930,537	4.00
5.00	PLANT OPERATION & MAINTENANCE	2,675	31,524	34,199	5.00
6.00	LAUNDRY & LINEN SERVICE	0	537	537	6.00
7.00	HOUSEKEEPING	0	8,138	8,138	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	107,245	107,245	9.00
10.00	ROUTINE MEDICAL SUPPLIES	32	177	209	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	163,666	116,758	280,424	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,074,669	0	1,074,669	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	54,067	0	54,067	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	377,749	0	377,749	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	1,823,077	1,475,618	3,298,695	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet 0-6

Hospice CCN: 14-1658

To 06/30/2017

Part I
Date/Time Prepared:
11/28/2017 4:13 pm

Descriptions	Hospice I				SUBTOTAL	
	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT		
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6,179	6,179			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,019		21,019		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	403,723	0	0	403,723	3.00
4.00	ADMINISTRATIVE & GENERAL	930,537	6,179	21,019	95,732	1,053,467
5.00	PLANT OPERATION & MAINTENANCE	34,199	0	0	0	34,199
6.00	LAUNDRY & LINEN SERVICE	537	0	0	0	537
7.00	HOUSEKEEPING	8,138	0	0	0	8,138
8.00	DIETARY	0	0	0	0	0
9.00	NURSING ADMINISTRATION	107,245	0	0	0	107,245
10.00	ROUTINE MEDICAL SUPPLIES	209	0	0	0	209
11.00	MEDICAL RECORDS	0	0	0	0	0
12.00	STAFF TRANSPORTATION	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0
14.00	PHARMACY	280,424	0	0	0	280,424
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0
16.00	OTHER GENERAL SERVICE	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0
51.00	HOSPICE ROUTINE HOME CARE	1,074,669			302,865	1,377,534
52.00	HOSPICE INPATIENT RESPIRE CARE	54,067	0	0	4,710	58,777
53.00	HOSPICE GENERAL INPATIENT CARE	377,749	0	0	416	378,165
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0				0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	3,298,695	6,179	21,019	403,723	3,298,695

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 14-0032	Period: From 07/01/2016	Worksheet 0-6
		Hospice CCN: 14-1658	To 06/30/2017	Part I
				Date/Time Prepared: 11/28/2017 4:13 pm

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL	1,053,467				4.00
5.00	PLANT OPERATION & MAINTENANCE	16,046	50,245			5.00
6.00	LAUNDRY & LINEN SERVICE	252	0	789		6.00
7.00	HOUSEKEEPING	3,818	0		11,956	7.00
8.00	DIETARY	0	0		0	8.00
9.00	NURSING ADMINISTRATION	50,320	0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	98	0		0	10.00
11.00	MEDICAL RECORDS	0	0		0	11.00
12.00	STAFF TRANSPORTATION	0	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0	13.00
14.00	PHARMACY	131,576	0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	646,343				51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	27,578	5,356	0	1,274	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	177,436	44,889	0	10,682	53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	61.00
62.00	FUNDRAISING	0	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0	65.00
66.00	RESIDENTIAL CARE	0	0	789	0	66.00
67.00	ADVERTISING	0	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0	68.00
69.00	THRIFT STORE	0	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	1,053,467	50,245	789	11,956	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 14-0032	Period: From 07/01/2016	Worksheet 0-6
		Hospice CCN: 14-1658	To 06/30/2017	Part I
				Date/Time Prepared: 11/28/2017 4:13 pm

Descriptions	Hospice I					
	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00	157,565					9.00
10.00	0	307				10.00
11.00	0		0			11.00
12.00	0			0		12.00
13.00	0			0	0	13.00
14.00	0			0	0	14.00
15.00	0			0	0	15.00
16.00	0			0	0	16.00
17.00	0			0	0	17.00
LEVEL OF CARE						
50.00	0	0	0	0	0	50.00
51.00	157,565	301	0	0	0	51.00
52.00	0	1	0	0	0	52.00
53.00	0	5	0	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0			0	0	60.00
61.00	0			0	0	61.00
62.00	0			0	0	62.00
63.00	0			0	0	63.00
64.00	0			0	0	64.00
65.00	0			0	0	65.00
66.00	0			0	0	66.00
67.00	0			0	0	67.00
68.00	0			0	0	68.00
69.00	0			0	0	69.00
70.00						70.00
71.00	0			0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	157,565	307	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet 0-6

Hospice CCN: 14-1658

To 06/30/2017

Part I
Date/Time Prepared:
11/28/2017 4:13 pm

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	412,000					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				0		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	404,428	0	0		2,586,171	51.00
52.00	6,958	0	0	0	99,944	52.00
53.00	614	0	0	0	611,791	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	789	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	412,000	0	0	0	3,298,695	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0032
Hospice CCN: 14-1658

Period:
From 07/01/2016
To 06/30/2017

Worksheet 0-6
Part II
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Descriptions		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		(SQUARE FEET)	(DOLLAR VALUE)				
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIX	912					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		238				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,128,338			3.00
4.00	ADMINISTRATIVE & GENERAL	912	238	267,555	-1,053,467	2,245,228	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	34,199	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	537	6.00
7.00	HOUSEKEEPING	0	0	0	0	8,138	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	107,245	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	209	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	280,424	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			846,457	0	1,377,534	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	13,163	0	58,777	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	1,163	0	378,165	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	6,179	21,019	403,723		1,053,467	100.00
101.00	UNIT COST MULTIPLIER	6.775219	88.315126	0.357803		0.469203	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPI CE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0032
Hospice CCN: 14-1658

Period:
From 07/01/2016
To 06/30/2017

Worksheet 0-6
Part II
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	197					5.00
6.00	LAUNDRY & LINEN SERVICE	0	1				6.00
7.00	HOUSEKEEPING	0		197			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		69,910	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPI CE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPI CE ROUTINE HOME CARE					69,910	51.00
52.00	HOSPI CE INPATIENT RESPI TE CARE	21	0	21	0	0	52.00
53.00	HOSPI CE GENERAL INPATIENT CARE	176	0	176	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPI CE/PALLI ATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLI ATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	1	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	50,245	789	11,956	0	157,565	100.00
101.00	UNIT COST MULTIPLIER	255.050761	789.000000	60.690355	0.000000	2.253826	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0032
Hospice CCN: 14-1658

Period:
From 07/01/2016
To 06/30/2017

Worksheet 0-6
Part II
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	12,443					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	163,666	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	12,222	0	0	0	160,658	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	21	0	0	0	2,764	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	200	0	0	0	244	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	307	0	0	0	412,000	100.00
101.00	UNIT COST MULTIPLIER	0.024673	0.000000	0.000000	0.000000	2.517322	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0032

Hospice CCN: 14-1658

Period:
From 07/01/2016
To 06/30/2017

Worksheet 0-6
Part II
Date/Time Prepared:
11/28/2017 4:13 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0			99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet 0-7

Hospice CCN: 14-1658

To 06/30/2017

Date/Time Prepared: 11/28/2017 4:13 pm

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS		0	1.00	2.00	3.00	4.00	
1.00	PHYSICAL THERAPY	66.00	0.600929	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.305849	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.231068	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.226219	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0.308998	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	BACTERIOLOGY & MICROBIOLOGY	76.00	0.000000	0	0	0	10.00
10.01	VASCULAR LAB	76.01	0.171205	0	0	0	10.01
10.03	WOUND CARE	76.03	0.256888	0	0	0	10.03
10.97	CARDIAC REHABILITATION	76.97	0.353801	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)		Shared Service Costs by LOC			
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	10.00
10.01	VASCULAR LAB	0	0	0	0	0	10.01
10.03	WOUND CARE	0	0	0	0	0	10.03
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)	0	0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0032

Period: From 07/01/2016

Worksheet 0-8

Hospice CCN: 14-1658

To 06/30/2017

Date/Time Prepared: 11/28/2017 4:13 pm

		Hospice I		
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL
		1.00	2.00	3.00
HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0
3.00	Total average cost per diem (line 1 divided by line 2)			0.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0	0
5.00	Program cost (line 3 times line 4)	0	0	0
HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			2,586,171
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			12,222
8.00	Total average cost per diem (line 6 divided by line 7)			211.60
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	11,167	676	11,843
10.00	Program cost (line 8 times line 9)	2,362,937	143,042	2,505,979
HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			99,944
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			21
13.00	Total average cost per diem (line 11 divided by line 12)			4,759.24
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	21	0	21
15.00	Program cost (line 13 times line 14)	99,944	0	99,944
HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			611,791
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			200
18.00	Total average cost per diem (line 16 divided by line 17)			3,058.96
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	176	15	191
20.00	Program cost (line 18 times line 19)	538,377	45,884	584,261
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,297,906
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			12,443
23.00	Average cost per diem (line 21 divided by line 22)			265.04

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0032	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/28/2017 4:13 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,540,668	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		34,734	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		42.81	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,575,402	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00