

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: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet S Parts I-III Date/Time Prepared: 1/22/2019 10:46 am
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 1/22/2019 Time: 10:46 am

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital Sycamore (14-2006) for the cost reporting period beginning 09/01/2017 and ending 08/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

SR VICE PRESIDENT OF REIMBURSEMENT
 Title _____

Date _____

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	286,933	-617	0	1,091,687	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
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00 Total	0	286,933	-617	0	1,091,687	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-2006		Period: From 09/01/2017 To 08/31/2018		Worksheet S-2 Part I Date/Time Prepared: 1/8/2019 3:21 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 225 Edward Street			PO Box:				1.00				
2.00	City: Sycamore			State: IL		Zip Code: 60178		County: DeKalb			2.00	
		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			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		Kindred Hospital Sycamore		142006	20994	2	01/01/1988	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2017	08/31/2018		20.00		
21.00	Type of Control (see instructions)						4			21.00		
							1.00	2.00	3.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		24.00	

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
		Urban/Rural		S		Date of Geogr			
		1.00		2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
		Beginning:		Ending:					
		1.00		2.00					
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
		Y/N		Y/N					
		1.00		2.00					
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
		V		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	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
		Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
		NAHE 413.85 Y/N		Worksheet A Line #		Pass-Through Qualification Criterion Code			
		1.00		2.00		3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N			60.00

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
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. 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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			Y	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00	
		V	XIX			
		1.00	2.00			
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06	
Rural Providers						
105.00	Does this hospital qualify as a CAH?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/8/2019 3:21 pm		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	218,022	0	944,576		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		189003		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/8/2019 3:21 pm
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1.00	2.00		3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: KINDRED HEALTHCARE OPERATING LLC	Contractor's Name: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 05901			141.00	
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:				142.00	
143.00	City: LOUISVILLE	State: KY	Zip Code:	40202		143.00	
144.00 Are provider based physicians' costs included in Worksheet A?							
					1.00	Y	144.00
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.							
					1.00	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.							
					1.00	N	146.00
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							
					1.00	N	147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							
					1.00	N	148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							
					1.00	N	149.00
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)							
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
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	N	161.00	
Multi campus							
165.00 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.					1.00	N	165.00
Name County State Zip Code CBSA FTE/Campus							
0 1.00 2.00 3.00 4.00 5.00							
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	166.00
166.01						0.00	166.01
166.02						0.00	166.02
166.03						0.00	166.03
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.					1.00	N	167.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							
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)					1.00		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)							
					1.00	0.00	169.00
Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							
					1.00	2.00	170.00
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)							
					1.00	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2006		Period: From 09/01/2017 To 08/31/2018		Worksheet S-2 Part II Date/Time Prepared: 1/8/2019 3:21 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				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2019			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/30/2018	Y	11/30/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part II Date/Time Prepared: 1/8/2019 3:21 pm		
		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N	21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been 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?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2018	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID		SIMPSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE OPERATING LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967945		KindredReimbursement@kindred.com		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part II Date/Time Prepared: 1/8/2019 3:21 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
1/8/2019 3:21 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	69	25,185	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)		69	25,185	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		69	25,185	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		69			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
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
1/8/2019 3:21 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)	5,169	2,779	12,889			1.00
2.00 HMO and other (see instructions)	1,065	1,302				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,169	2,779	12,889			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	5,169	2,779	12,889	0.00	127.40	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	127.40	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	4					33.00
33.01 LTCH site neutral days and discharges	904					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
1/8/2019 3:21 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	202	95	479	1.00
2.00 HMO and other (see instructions)			39	49		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	202	95	479	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			33			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part II
Date/Time Prepared:
1/8/2019 3:21 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	7,764,047	0	7,764,047	265,286.69	29.27
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	91,876	91,876	1,932.00	47.55
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,323,465	0	1,323,465	18,832.00	70.28
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		879,535	0	879,535	8,238.00	106.77
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		1,266,659	0	1,266,659	26,944.45	47.01
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,172,667	0	1,172,667		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		14,043	0	14,043		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	89,059	0	89,059	1,181.95	75.35
27.00	Administrative & General	5.00	1,037,214	0	1,037,214	26,569.32	39.04

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part II
Date/Time Prepared:
1/8/2019 3:21 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	6,621	0	6,621	212.00	31.23	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	202,765	0	202,765	16,518.00	12.28	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	253,553	0	253,553	15,865.00	15.98	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	538,428	0	538,428	13,722.00	39.24	38.00
39.00	Central Services and Supply	86,531	0	86,531	3,353.00	25.81	39.00
40.00	Pharmacy	392,416	0	392,416	9,610.00	40.83	40.00
41.00	Medical Records & Medical Records Library	313,506	0	313,506	10,798.00	29.03	41.00
42.00	Social Service	384,009	-91,876	292,133	6,141.00	47.57	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet S-3
Part III
Date/Time Prepared:
1/8/2019 3:21 pm

	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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)	7,770,668	0	7,770,668	265,498.69	29.27	1.00
2.00	Excluded area salaries (see instructions)	0	91,876	91,876	1,932.00	47.55	2.00
3.00	Subtotal salaries (line 1 minus line 2)	7,770,668	-91,876	7,678,792	263,566.69	29.13	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,469,659	0	3,469,659	54,014.45	64.24	4.00
5.00	Subtotal wage-related costs (see inst.)	1,172,667	0	1,172,667	0.00	15.27	5.00
6.00	Total (sum of lines 3 thru 5)	12,412,994	-91,876	12,321,118	317,581.14	38.80	6.00
7.00	Total overhead cost (see instructions)	3,304,102	-91,876	3,212,226	103,970.27	30.90	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 1/8/2019 3:21 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	9,124	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	454,230	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	4,837	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	4,290	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)	44,500	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	18,575	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	536,298	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	83,681	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	17,134	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,172,669	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: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet S-3 Part V Date/Time Prepared: 1/8/2019 3:21 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		1,323,465	1,172,667
2.00	Hospital		1,323,465	1,172,667
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		0	0
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A
Date/Time Prepared:
1/8/2019 3:21 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		3,565,116	3,565,116	137,681	3,702,797	1.00
2.00	00200		326,080	326,080	48,538	374,618	2.00
3.00	00300		199,910	199,910	-199,910	0	3.00
4.00	00400	89,059	1,261,056	1,350,115	0	1,350,115	4.00
5.00	00500	1,037,214	5,785,470	6,822,684	603	6,823,287	5.00
7.00	00700	0	733,393	733,393	-96,905	636,488	7.00
8.00	00800	0	125,430	125,430	0	125,430	8.00
9.00	00900	202,765	49,130	251,895	317	252,212	9.00
10.00	01000	253,553	150,243	403,796	0	403,796	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	538,428	8,956	547,384	0	547,384	13.00
14.00	01400	86,531	6,381	92,912	42,639	135,551	14.00
15.00	01500	392,416	257,206	649,622	2,606	652,228	15.00
16.00	01600	313,506	87,240	400,746	0	400,746	16.00
17.00	01700	384,009	22,686	406,695	-97,304	309,391	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,507,098	1,066,401	4,573,499	330,539	4,904,038	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	97,344	67,592	164,936	1,096	166,032	50.00
54.00	05400	83,019	121,521	204,540	64,381	268,921	54.00
60.00	06000	54,613	340,972	395,585	28,188	423,773	60.00
65.00	06500	724,492	19,445	743,937	193,513	937,450	65.00
66.00	06600	0	1,060,948	1,060,948	2,404	1,063,352	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	735,547	735,547	-555,690	179,857	71.00
73.00	07300	0	1,030,742	1,030,742	0	1,030,742	73.00
74.00	07400	0	405,648	405,648	0	405,648	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		7,764,047	17,427,113	25,191,160	-97,304	25,093,856	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	97,304	97,304	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00		7,764,047	17,427,113	25,191,160	0	25,191,160	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A
Date/Time Prepared:
1/8/2019 3:21 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-82,768	3,620,029	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-50,265	324,353	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,583	1,347,532	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,730,823	5,092,464	5.00
7.00	00700	OPERATION OF PLANT	-922	635,566	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,430	8.00
9.00	00900	HOUSEKEEPING	0	252,212	9.00
10.00	01000	DIETARY	-20,541	383,255	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	547,384	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	135,551	14.00
15.00	01500	PHARMACY	0	652,228	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-832	399,914	16.00
17.00	01700	SOCIAL SERVICE	0	309,391	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-69,141	4,834,897	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	166,032	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	268,921	54.00
60.00	06000	LABORATORY	-5,662	418,111	60.00
65.00	06500	RESPIRATORY THERAPY	0	937,450	65.00
66.00	06600	PHYSICAL THERAPY	-66,962	996,390	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	179,857	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,030,742	73.00
74.00	07400	RENAL DIALYSIS	0	405,648	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,030,499	23,063,357	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	97,304	194.00
194.01	07951	IDLE SPACE	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,030,499	23,160,661	200.00

RECLASSIFICATIONS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-6

Date/Time Prepared:
1/8/2019 3:21 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	NONALLOWABLE CLINICAL	194.00	91,876	5,428	1.00	
	LIASON					
	TOTALS		91,876	5,428		
B - RECLASS OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	58,358	1.00	
	TOTALS		0	58,358		
C - RECLASS NON-CHARGEABLE MED SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	603	1.00	
2.00	HOUSEKEEPING	9.00	0	317	2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	42,639	3.00	
4.00	PHARMACY	15.00	0	2,606	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	330,539	5.00	
6.00	OPERATING ROOM	50.00	0	1,096	6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,116	7.00	
8.00	LABORATORY	60.00	0	25,548	8.00	
9.00	RESPIRATORY THERAPY	65.00	0	88,464	9.00	
10.00	PHYSICAL THERAPY	66.00	0	2,404	10.00	
	TOTALS		0	497,332		
D - RECLASS JLL EQUIPMENT SERV CONTRACTS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	61,265	1.00	
2.00	LABORATORY	60.00	0	2,640	2.00	
3.00	RESPIRATORY THERAPY	65.00	0	33,000	3.00	
	TOTALS		0	96,905		
E - RECLASS OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	13,691	1.00	
	TOTALS		0	13,691		
500.00	Grand Total: Increases		91,876	671,714	500.00	

RECLASSIFICATIONS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-6

Date/Time Prepared:
1/8/2019 3:21 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - RECLASS NON ALLOWABLE CASE MANAGER						
1.00	SOCIAL SERVICE	17.00	91,876	5,428	0	1.00
	TOTALS		91,876	5,428		
B - RECLASS OXYGEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	58,358	0	1.00
	TOTALS		0	58,358		
C - RECLASS NON-CHARGEABLE MED SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	497,332	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
	TOTALS		0	497,332		
D - RECLASS JLL EQUIPMENT SERV CONTRACTS						
1.00	OPERATION OF PLANT	7.00	0	96,905	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	96,905		
E - RECLASS OXYGEN						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,691	9	1.00
	TOTALS		0	13,691		
500.00	Grand Total: Decreases		91,876	671,714		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-7
Part I
Date/Time Prepared:
1/8/2019 3:21 pm

	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	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	8,587,346	262,427	0	262,427	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	4,154,622	98,198	0	98,198	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,741,968	360,625	0	360,625	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,741,968	360,625	0	360,625	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	8,849,773	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	3,999,902	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	12,849,675	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	12,849,675	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-7
Part II
Date/Time Prepared:
1/8/2019 3:21 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	232,319	3,332,797	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	153,382	172,698	0	0	0	2.00
3.00	Total (sum of lines 1-2)	385,701	3,505,495	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	3,565,116				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	326,080				2.00
3.00	Total (sum of lines 1-2)	0	3,891,196				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-7
Part III
Date/Time Prepared:
1/8/2019 3:21 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	8,849,773	0	8,849,773	0.688716	17,833	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,999,902	0	3,999,902	0.311284	8,060	2.00
3.00	Total (sum of lines 1-2)	12,849,675	0	12,849,675	1.000000	25,893	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	119,848	0	137,681	159,390	3,332,797	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	54,169	0	62,229	89,426	172,698	2.00
3.00	Total (sum of lines 1-2)	174,017	0	199,910	248,816	3,505,495	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	7,994	119,848	0	3,620,029	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,060	54,169	0	324,353	2.00
3.00	Total (sum of lines 1-2)	0	16,054	174,017	0	3,944,382	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-8

Date/Time Prepared:
1/8/2019 3:21 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 #			
				3.00	4.00			
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-2,378		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-16,644		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-922		OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-97,341				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	-475,347				0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-20,541		DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others			0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00	Sale of drugs to other than patients			0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-832		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00	Vending machines			0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-8

Date/Time Prepared:
1/8/2019 3:21 pm

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
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.00
33.01 MISCELLANEOUS INCOME	B	-73,835	ADMINISTRATIVE & GENERAL		5.00	0 33.01
33.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.02
33.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.03
33.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.04
33.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.05
33.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.06
33.07 PROFESSIONAL FEES - CAPITAL PROJECT	A	-14,190	ADMINISTRATIVE & GENERAL		5.00	0 33.07
33.08 MEDICARE BAD DEBT - PART A	A	-232,899	ADMINISTRATIVE & GENERAL		5.00	0 33.08
33.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.09
33.10 OTHER MEDICARE NON ALLOWABLE	A	-83,961	ADMINISTRATIVE & GENERAL		5.00	0 33.10
33.11 OTHER OPERATING - PATIENT RELATIONS	A	-1,333	ADMINISTRATIVE & GENERAL		5.00	0 33.11
33.12 OTHER OPERATING - PUBLIC RELATIONS	A	-2,731	ADMINISTRATIVE & GENERAL		5.00	0 33.12
33.13 OTHER OPERATING - MARKETING	A	-66,060	ADMINISTRATIVE & GENERAL		5.00	0 33.13
33.14 OTHER OPERATING - INTEREST	A	-43	ADMINISTRATIVE & GENERAL		5.00	0 33.14
33.15 OTHER OPERATING - CASH OVER SHORT	A	-36	ADMINISTRATIVE & GENERAL		5.00	0 33.15
33.16 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.16
33.17 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.17
33.18 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.18
33.19 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.19
33.20 OTHER OPERATING - TRADE SHOW BOOTH	A	-25	ADMINISTRATIVE & GENERAL		5.00	0 33.20
33.21 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.21
33.22 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.22
33.23 CHARITABLE CONTRIBUTIONS	A	-16,698	ADMINISTRATIVE & GENERAL		5.00	0 33.23
33.24 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.24
33.25 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.25
33.26 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.26
33.27 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.27
33.28 AGGREGATE CAPITAL EROSION	A	-263,924	ADMINISTRATIVE & GENERAL		5.00	0 33.28
33.29 CABLE TV AND SATELLITE	A	-16,245	ADMINISTRATIVE & GENERAL		5.00	0 33.29
33.30 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.30
33.31 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.31
33.32 RENT - OTHER	A	-189,294	ADMINISTRATIVE & GENERAL		5.00	0 33.32
33.33 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.33
33.34 MALPRACTICE TAIL LIABILITY	A	-285,383	ADMINISTRATIVE & GENERAL		5.00	0 33.34
33.35 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.35
33.36 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.36
33.37 PHYSICIAN BILLING COLLECTION FEES	A	-1,101	ADMINISTRATIVE & GENERAL		5.00	0 33.37
33.38 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.38
33.39 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.39

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-8

Date/Time Prepared:
1/8/2019 3:21 pm

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
33.40 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.40
33.41 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.41
33.42 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.42
33.43 DISTRICT OFFICE SALES AND MARKETING	A	-24,262	ADMINISTRATIVE & GENERAL		5.00	0 33.43
33.44 DISTRICT OFC SALES AND MKT BENEFITS	A	-2,008	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.44
33.45 BUSINESS INTERRUPTIONS INS PREMIUM	A	-9,839	CAP REL COSTS-BLDG & FIXT		1.00	12 33.45
34.00 MEDICARE VS BOOK BLDG	A	-73,330	CAP REL COSTS-BLDG & FIXT		1.00	9 34.00
34.01 MEDICARE VS BOOK MOV EQUIP	A	-68,649	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.01
34.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.02
34.03 ASSET ADD-ON BLDG	A	1,430	CAP REL COSTS-BLDG & FIXT		1.00	9 34.03
34.04 ASSET ADD-ON MOV EQUIP	A	19,376	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.04
34.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.05
34.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.06
34.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.07
34.08 NON ALLOWABLE LOBBYING FEES	A	-7,428	ADMINISTRATIVE & GENERAL		5.00	0 34.08
34.09 OTHER NONALLOW DUES & SUBSCRIPTIONS	A	-2,005	ADMINISTRATIVE & GENERAL		5.00	0 34.09
34.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.10
34.11 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.11
34.12 PATIENT PHONE - DEPREC BLDG	A	-1,029	CAP REL COSTS-BLDG & FIXT		1.00	9 34.12
34.13 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.13
34.14 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.14
34.15 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.15
34.16 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.16
34.17 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.17
34.18 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.18
34.19 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.19
34.20 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.20
34.21 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.21
34.22 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.22
34.23 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.23
34.24 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.24
34.25 Remove asset transfer depreciation	A	-992	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.25
34.26 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.26
34.27 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.27
34.28 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 34.28
35.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.00
35.01 PHYSICIAN FEE ADJUSTMENT	A	-22,538	ADMINISTRATIVE & GENERAL		5.00	0 35.01
35.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.02
35.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.03

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
35.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.04
35.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.05
35.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.06
35.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.07
35.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.08
35.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.09
35.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.10
35.11 PHYSICIAN FEE ADJUSTMENT	A	22,538	ADULTS & PEDIATRICS		30.00	0 35.11
35.12 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.12
35.13 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.13
35.14 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.14
35.15 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.15
35.16 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.16
35.17 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.17
35.18 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.18
35.19 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.19
35.20 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.20
35.21 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.21
35.22 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.22
35.23 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.23
35.24 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.24
35.25 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 35.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,030,499				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: 14-2006
 Period: From 09/01/2017 To 08/31/2018
 Worksheet A-8-1
 Date/Time Prepared: 1/8/2019 3:21 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	1,963,159	1,269,793 1.00
2.00	0.00			0	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	0	575 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	0	1,101,176 4.00
4.01	66.00	PHYSICAL THERAPY	Therapy Services	993,503	1,060,465 4.01
4.22	60.00	LABORATORY	Hospital Related services	74,748	74,748 4.22
5.00	0			3,031,410	3,506,757 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	B	KHOLLC	100.00	Admin & Gen	100.00	6.00
7.00	B	KHOLLC	100.00	Cornerstone	100.00	7.00
8.00	B	KHOLLC	100.00	Cornerstone	100.00	8.00
9.00	B	KHOLLC	100.00	RehabCare	100.00	9.00
10.00	B	KHOLLC	100.00	KH Chicago N.	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-8-1

Date/Time Prepared:
1/8/2019 3:21 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	693,366	0		1.00
2.00	0	0		2.00
3.00	-575	0		3.00
4.00	-1,101,176	0		4.00
4.01	-66,962	0		4.01
4.22	0	0		4.22
5.00	-475,347			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	Home Office Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00	Therapy Svcs		9.00
10.00	Lab		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: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet A-8-2

Date/Time Prepared:
1/8/2019 3:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	844,577	0	844,577	211,500	8,044	1.00
2.00	30.00	DR. B	60,636	60,636	0	211,500	0	2.00
3.00	30.00	DR. C	13,350	0	13,350	211,500	88	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	60.00	DR. E	12,420	0	12,420	260,300	54	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			930,983	60,636	870,347		8,186	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	817,936	40,897	0	0	0	1.00
2.00	30.00	DR. B	0	0	0	0	0	2.00
3.00	30.00	DR. C	8,948	447	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	60.00	DR. E	6,758	338	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			833,642	41,682	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	DR. A	0	817,936	26,641	26,641	1.00
2.00	30.00	DR. B	0	0	0	60,636	2.00
3.00	30.00	DR. C	0	8,948	4,402	4,402	3.00
4.00	0.00		0	0	0	0	4.00
5.00	60.00	DR. E	0	6,758	5,662	5,662	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	833,642	36,705	97,341	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet B
Part I
Date/Time Prepared:
1/8/2019 3:21 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	3,620,029	3,620,029			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	324,353		324,353		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,347,532	52,607	4,714	1,404,853	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,092,464	603,529	54,076	189,855	5.00
7.00 00700	OPERATION OF PLANT	635,566	487,388	43,670	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	125,430	60,979	5,464	0	8.00
9.00 00900	HOUSEKEEPING	252,212	52,079	4,666	37,115	9.00
10.00 01000	DIETARY	383,255	346,485	31,045	46,411	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	547,384	33,221	2,977	98,555	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	135,551	363,052	32,529	15,839	14.00
15.00 01500	PHARMACY	652,228	89,177	7,990	71,829	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	399,914	51,902	4,650	57,385	16.00
17.00 01700	SOCIAL SERVICE	309,391	28,551	2,558	53,473	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,834,897	1,167,051	104,567	641,950	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	166,032	0	0	17,818	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	268,921	36,922	3,308	15,196	54.00
60.00 06000	LABORATORY	418,111	78,250	7,011	9,997	60.00
65.00 06500	RESPIRATORY THERAPY	937,450	33,573	3,008	132,613	65.00
66.00 06600	PHYSICAL THERAPY	996,390	135,263	12,120	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,857	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,030,742	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	405,648	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	23,063,357	3,620,029	324,353	1,388,036	23,046,540
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	97,304	0	0	16,817	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	23,160,661	3,620,029	324,353	1,404,853	23,160,661

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet B Part I Date/Time Prepared: 1/8/2019 3:21 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,939,924				5.00
7.00	00700	OPERATION OF PLANT	402,402	1,569,026			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	66,183	38,634	296,690		8.00
9.00	00900	HOUSEKEEPING	119,370	32,995	0	498,437	9.00
10.00	01000	DIETARY	278,425	219,521	0	73,072	1,378,214
11.00	01100	CAFETERIA	0	0	0	0	393,092
13.00	01300	NURSING ADMINISTRATION	235,289	21,048	0	7,006	0
14.00	01400	CENTRAL SERVICES & SUPPLY	188,666	230,017	0	76,565	0
15.00	01500	PHARMACY	283,264	56,499	0	18,807	0
16.00	01600	MEDICAL RECORDS & LIBRARY	177,242	32,883	0	10,946	0
17.00	01700	SOCIAL SERVICE	135,893	18,089	0	6,021	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,327,733	739,403	296,690	246,125	969,270
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	63,415	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,877	23,392	0	7,787	0
60.00	06000	LABORATORY	177,076	49,576	0	16,502	0
65.00	06500	RESPIRATORY THERAPY	381,714	21,271	0	7,080	0
66.00	06600	PHYSICAL THERAPY	394,520	85,698	0	28,526	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,038	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	355,533	0	0	0	0
74.00	07400	RENAL DIALYSIS	139,920	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,900,560	1,569,026	296,690	498,437	1,362,362
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CLINICAL LIAISON	39,364	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	CONTACT CENTER	0	0	0	0	0
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0	15,852
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	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 through 201)	5,939,924	1,569,026	296,690	498,437	1,378,214

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet B Part I Date/Time Prepared: 1/8/2019 3:21 pm
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	393,092					11.00
13.00	01300	27,794	973,274				13.00
14.00	01400	7,941	0	1,050,160			14.00
15.00	01500	19,853	0	24,747	1,224,394		15.00
16.00	01600	19,853	0	4,543	0	759,318	16.00
17.00	01700	15,883	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	242,207	957,576	544,910	26,402	313,257	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,971	15,698	1,720	0	3,574	50.00
54.00	05400	3,971	0	5,022	0	14,619	54.00
60.00	06000	3,971	0	40,477	0	66,708	60.00
65.00	06500	47,648	0	142,708	0	111,245	65.00
66.00	06600	0	0	3,774	0	36,300	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	282,259	0	6,528	71.00
73.00	07300	0	0	0	1,197,992	194,891	73.00
74.00	07400	0	0	0	0	12,196	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		393,092	973,274	1,050,160	1,224,394	759,318	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		393,092	973,274	1,050,160	1,224,394	759,318	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet B
Part I
Date/Time Prepared:
1/8/2019 3:21 pm

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	569,859			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	569,859	13,981,897	0	13,981,897	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	272,228	0	272,228	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	491,015	0	491,015	54.00
60.00	06000	LABORATORY	0	867,679	0	867,679	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,818,310	0	1,818,310	65.00
66.00	06600	PHYSICAL THERAPY	0	1,692,591	0	1,692,591	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	530,682	0	530,682	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,779,158	0	2,779,158	73.00
74.00	07400	RENAL DIALYSIS	0	557,764	0	557,764	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	569,859	22,991,324	0	22,991,324	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	153,485	0	153,485	194.00
194.01	07951	IDLE SPACE	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	15,852	0	15,852	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	569,859	23,160,661	0	23,160,661	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet B
Part II
Date/Time Prepared:
1/8/2019 3:21 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	52,607	4,714	57,321	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	179,133	603,529	54,076	836,738	5.00
7.00 00700	OPERATION OF PLANT	0	487,388	43,670	531,058	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	60,979	5,464	66,443	8.00
9.00 00900	HOUSEKEEPING	0	52,079	4,666	56,745	9.00
10.00 01000	DIETARY	0	346,485	31,045	377,530	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	33,221	2,977	36,198	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	363,052	32,529	395,581	14.00
15.00 01500	PHARMACY	0	89,177	7,990	97,167	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	51,902	4,650	56,552	16.00
17.00 01700	SOCIAL SERVICE	0	28,551	2,558	31,109	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,167,051	104,567	1,271,618	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	36,922	3,308	40,230	54.00
60.00 06000	LABORATORY	0	78,250	7,011	85,261	60.00
65.00 06500	RESPIRATORY THERAPY	0	33,573	3,008	36,581	65.00
66.00 06600	PHYSICAL THERAPY	0	135,263	12,120	147,383	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	179,133	3,620,029	324,353	4,123,515	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	194.00
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	179,133	3,620,029	324,353	4,123,515	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-2006		Period: From 09/01/2017 To 08/31/2018		Worksheet B Part II Date/Time Prepared: 1/8/2019 3:21 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	844,485				5.00
7.00	00700	OPERATION OF PLANT	57,210	588,268			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,409	14,485	90,337		8.00
9.00	00900	HOUSEKEEPING	16,971	12,371	0	87,601	9.00
10.00	01000	DIETARY	39,584	82,304	0	12,842	514,154
11.00	01100	CAFETERIA	0	0	0	0	146,646
13.00	01300	NURSING ADMINISTRATION	33,451	7,891	0	1,231	0
14.00	01400	CENTRAL SERVICES & SUPPLY	26,823	86,239	0	13,456	0
15.00	01500	PHARMACY	40,272	21,183	0	3,305	0
16.00	01600	MEDICAL RECORDS & LIBRARY	25,199	12,329	0	1,924	0
17.00	01700	SOCIAL SERVICE	19,320	6,782	0	1,058	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	330,935	277,222	90,337	43,258	361,594
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,016	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,906	8,770	0	1,369	0
60.00	06000	LABORATORY	25,175	18,587	0	2,900	0
65.00	06500	RESPIRATORY THERAPY	54,269	7,975	0	1,244	0
66.00	06600	PHYSICAL THERAPY	56,089	32,130	0	5,014	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,820	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	50,547	0	0	0	0
74.00	07400	RENAL DIALYSIS	19,893	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	838,889	588,268	90,337	87,601	508,240
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CLINICAL LIAISON	5,596	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	CONTACT CENTER	0	0	0	0	0
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	0	5,914
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	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 through 201)	844,485	588,268	90,337	87,601	514,154

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-2006		Period: From 09/01/2017 To 08/31/2018		Worksheet B Part II Date/Time Prepared: 1/8/2019 3:21 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	146,646					11.00
13.00	01300	10,369	93,162				13.00
14.00	01400	2,963	0	525,708			14.00
15.00	01500	7,406	0	12,388	184,652		15.00
16.00	01600	7,406	0	2,274	0	108,026	16.00
17.00	01700	5,925	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	90,359	91,659	272,782	3,982	44,565	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,481	1,503	861	0	508	50.00
54.00	05400	1,481	0	2,514	0	2,080	54.00
60.00	06000	1,481	0	20,262	0	9,491	60.00
65.00	06500	17,775	0	71,440	0	15,827	65.00
66.00	06600	0	0	1,889	0	5,164	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	141,298	0	929	71.00
73.00	07300	0	0	0	180,670	27,727	73.00
74.00	07400	0	0	0	0	1,735	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		146,646	93,162	525,708	184,652	108,026	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		146,646	93,162	525,708	184,652	108,026	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet B Part II Date/Time Prepared: 1/8/2019 3:21 pm		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	66,376			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	66,376	2,970,878	0	2,970,878	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	14,096	0	14,096	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	72,970	0	72,970	54.00
60.00	06000	LABORATORY	0	163,565	0	163,565	60.00
65.00	06500	RESPIRATORY THERAPY	0	210,522	0	210,522	65.00
66.00	06600	PHYSICAL THERAPY	0	247,669	0	247,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	151,047	0	151,047	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	258,944	0	258,944	73.00
74.00	07400	RENAL DIALYSIS	0	21,628	0	21,628	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,376	4,111,319	0	4,111,319	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	6,282	0	6,282	194.00
194.01	07951	IDLE SPACE	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	5,914	0	5,914	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	66,376	4,123,515	0	4,123,515	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	41,081				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		41,081			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	597	597	7,674,988		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,849	6,849	1,037,214	-5,939,924	5.00
7.00 00700	OPERATION OF PLANT	5,531	5,531	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	692	692	0	0	8.00
9.00 00900	HOUSEKEEPING	591	591	202,765	0	9.00
10.00 01000	DIETARY	3,932	3,932	253,553	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	377	377	538,428	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	4,120	4,120	86,531	0	14.00
15.00 01500	PHARMACY	1,012	1,012	392,416	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	589	589	313,506	0	16.00
17.00 01700	SOCIAL SERVICE	324	324	292,133	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,244	13,244	3,507,098	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	97,344	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	419	419	83,019	0	54.00
60.00 06000	LABORATORY	888	888	54,613	0	60.00
65.00 06500	RESPIRATORY THERAPY	381	381	724,492	0	65.00
66.00 06600	PHYSICAL THERAPY	1,535	1,535	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	41,081	41,081	7,583,112	-5,939,924	17,106,616
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	91,876	0	114,121
194.01 07951	IDLE SPACE	0	0	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,620,029	324,353	1,404,853		5,939,924
203.00	Unit cost multiplier (Wkst. B, Part I)	88.119301	7.895450	0.183043		0.344929
204.00	Cost to be allocated (per Wkst. B, Part II)			57,321		844,485
205.00	Unit cost multiplier (Wkst. B, Part II)			0.007469		0.049039
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet B-1

Date/Time Prepared:
1/8/2019 3:21 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	28,104				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	692	12,889			8.00
9.00	00900	HOUSEKEEPING	591	0	26,821		9.00
10.00	01000	DIETARY	3,932	0	3,932	35,734	10.00
11.00	01100	CAFETERIA	0	0	0	10,192	99 11.00
13.00	01300	NURSING ADMINISTRATION	377	0	377	0	7 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,120	0	4,120	0	2 14.00
15.00	01500	PHARMACY	1,012	0	1,012	0	5 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	589	0	589	0	5 16.00
17.00	01700	SOCIAL SERVICE	324	0	324	0	4 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,244	12,889	13,244	25,131	61 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	1 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419	0	419	0	1 54.00
60.00	06000	LABORATORY	888	0	888	0	1 60.00
65.00	06500	RESPIRATORY THERAPY	381	0	381	0	12 65.00
66.00	06600	PHYSICAL THERAPY	1,535	0	1,535	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,104	12,889	26,821	35,323	99 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0 194.00
194.01	07951	IDLE SPACE	0	0	0	0	0 194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0 194.02
194.03	07953	DISTRIC OFFICE	0	0	0	0	0 194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0 194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0 194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0 194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0 194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0 194.08
194.09	07958	VISITOR MEALS	0	0	0	411	0 194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0 194.11
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,569,026	296,690	498,437	1,378,214	393,092 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.829277	23.018853	18.583834	38.568702	3,970.626263 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	588,268	90,337	87,601	514,154	146,646 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	20.931825	7.008845	3.266135	14.388370	1,481.272727 205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet B-1
Date/Time Prepared:
1/8/2019 3:21 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	62					13.00
14.00	01400	0	669,171				14.00
15.00	01500	0	15,769	1,053,458			15.00
16.00	01600	0	2,895	0	78,051,303		16.00
17.00	01700	0	0	0	0	12,889	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	61	347,221	22,716	32,198,049	12,889	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1	1,096	0	367,361	0	50.00
54.00	05400	0	3,200	0	1,502,752	0	54.00
60.00	06000	0	25,792	0	6,857,365	0	60.00
65.00	06500	0	90,935	0	11,435,571	0	65.00
66.00	06600	0	2,405	0	3,731,510	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	179,858	0	671,032	0	71.00
73.00	07300	0	0	1,030,742	20,033,982	0	73.00
74.00	07400	0	0	0	1,253,681	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		62	669,171	1,053,458	78,051,303	12,889	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00		973,274	1,050,160	1,224,394	759,318	569,859	202.00
203.00		15,697.967742	1.569345	1.162262	0.009728	44.212817	203.00
204.00		93,162	525,708	184,652	108,026	66,376	204.00
205.00		1,502.612903	0.785611	0.175282	0.001384	5.149818	205.00
206.00							206.00
207.00							207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet C
Part I
Date/Time Prepared:
1/8/2019 3:21 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	13,981,897		13,981,897	31,043	14,012,940	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	272,228		272,228	0	272,228	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	491,015		491,015	0	491,015	54.00
60.00	06000 LABORATORY	867,679		867,679	5,662	873,341	60.00
65.00	06500 RESPIRATORY THERAPY	1,818,310	0	1,818,310	0	1,818,310	65.00
66.00	06600 PHYSICAL THERAPY	1,692,591	0	1,692,591	0	1,692,591	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	530,682		530,682	0	530,682	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,779,158		2,779,158	0	2,779,158	73.00
74.00	07400 RENAL DIALYSIS	557,764		557,764	0	557,764	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	22,991,324	0	22,991,324	36,705	23,028,029	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	22,991,324	0	22,991,324	36,705	23,028,029	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet C
Part I
Date/Time Prepared:
1/8/2019 3:21 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	32,198,049		32,198,049		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	367,361	0	367,361	0.741037	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,488,169	14,583	1,502,752	0.326744	54.00
60.00	06000	LABORATORY	6,753,170	104,195	6,857,365	0.126532	60.00
65.00	06500	RESPIRATORY THERAPY	11,397,401	38,170	11,435,571	0.159005	65.00
66.00	06600	PHYSICAL THERAPY	3,673,914	57,596	3,731,510	0.453594	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	668,246	2,786	671,032	0.790845	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,033,982	0	20,033,982	0.138722	73.00
74.00	07400	RENAL DIALYSIS	1,228,513	25,168	1,253,681	0.444901	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	77,808,805	242,498	78,051,303		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	77,808,805	242,498	78,051,303		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet C Part I Date/Time Prepared: 1/8/2019 3:21 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
44.00	04400 SKILLED NURSING FACILITY		44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.741037	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.326744	54.00
60.00	06000 LABORATORY	0.127358	60.00
65.00	06500 RESPIRATORY THERAPY	0.159005	65.00
66.00	06600 PHYSICAL THERAPY	0.453594	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.790845	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.138722	73.00
74.00	07400 RENAL DIALYSIS	0.444901	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000	90.00
91.00	09100 EMERGENCY	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet C
Part I
Date/Time Prepared:
1/8/2019 3:21 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX Hospital Cost			
				Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	13,981,897		13,981,897	31,043	14,012,940	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	272,228		272,228	0	272,228	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	491,015		491,015	0	491,015	54.00
60.00	06000 LABORATORY	867,679		867,679	5,662	873,341	60.00
65.00	06500 RESPIRATORY THERAPY	1,818,310	0	1,818,310	0	1,818,310	65.00
66.00	06600 PHYSICAL THERAPY	1,692,591	0	1,692,591	0	1,692,591	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	530,682		530,682	0	530,682	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,779,158		2,779,158	0	2,779,158	73.00
74.00	07400 RENAL DIALYSIS	557,764		557,764	0	557,764	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	22,991,324	0	22,991,324	36,705	23,028,029	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	22,991,324	0	22,991,324	36,705	23,028,029	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet C
Part I
Date/Time Prepared:
1/8/2019 3:21 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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,198,049		32,198,049			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	367,361	0	367,361	0.741037	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,488,169	14,583	1,502,752	0.326744	0.000000	54.00
60.00	06000	LABORATORY	6,753,170	104,195	6,857,365	0.126532	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	11,397,401	38,170	11,435,571	0.159005	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,673,914	57,596	3,731,510	0.453594	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	668,246	2,786	671,032	0.790845	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,033,982	0	20,033,982	0.138722	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,228,513	25,168	1,253,681	0.444901	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	77,808,805	242,498	78,051,303			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	77,808,805	242,498	78,051,303			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet C Part I Date/Time Prepared: 1/8/2019 3:21 pm
		Title XIX	Hospital	Cost

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-2006		Period: From 09/01/2017 To 08/31/2018		Worksheet D Part I Date/Time Prepared: 1/8/2019 3:21 pm	
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)	
Title XVIII		Hospital PPS					
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,970,878	0	2,970,878	12,889	230.50	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,970,878		2,970,878	12,889		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	5,169	1,191,455				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	5,169	1,191,455				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part II Date/Time Prepared: 1/8/2019 3:21 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	14,096	367,361	0.038371	133,497	5,122	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	72,970	1,502,752	0.048558	556,076	27,002	54.00
60.00	06000 LABORATORY	163,565	6,857,365	0.023852	2,866,196	68,365	60.00
65.00	06500 RESPIRATORY THERAPY	210,522	11,435,571	0.018409	4,892,273	90,062	65.00
66.00	06600 PHYSICAL THERAPY	247,669	3,731,510	0.066372	1,552,779	103,061	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	151,047	671,032	0.225097	256,789	57,802	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	258,944	20,033,982	0.012925	7,849,859	101,459	73.00
74.00	07400 RENAL DIALYSIS	21,628	1,253,681	0.017252	577,739	9,967	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	1,140,441	45,853,254		18,685,208	462,840	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part III Date/Time Prepared: 1/8/2019 3:21 pm
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	12,889	0.00	5,169 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0.00	0 31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0 44.00
200.00		Total (lines 30 through 199)	0	0	12,889	0.00	5,169 200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
44.00	04400	SKILLED NURSING FACILITY	0				44.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part IV Date/Time Prepared: 1/8/2019 3:21 pm
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Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part IV Date/Time Prepared: 1/8/2019 3:21 pm
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Cost Center Description		Title XVIII			Hospital	PPS	
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	367,361	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	1,502,752	0.000000	54.00
60.00	06000 LABORATORY	0	0	0	6,857,365	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	11,435,571	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	3,731,510	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	671,032	0.000000	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	20,033,982	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	1,253,681	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00	Total (lines 50 through 199)	0	0	0	45,853,254		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet D
Part IV
Date/Time Prepared:
1/8/2019 3:21 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	133,497	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	556,076	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	2,866,196	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	4,892,273	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,552,779	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	256,789	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	7,849,859	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	577,739	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Total (Lines 50 through 199)		18,685,208	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part V Date/Time Prepared: 1/8/2019 3:21 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.741037	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.326744	0	13,211	0	0	54.00
60.00	06000 LABORATORY	0.126532	0	1,086	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.159005	0	30,487	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.453594	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.790845	0	2,786	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.138722	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.444901	0	25,168	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00	Subtotal (see instructions)		0	72,738	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	72,738	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part V Date/Time Prepared: 1/8/2019 3:21 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	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,317	0	54.00
60.00	06000 LABORATORY	137	0	60.00
65.00	06500 RESPIRATORY THERAPY	4,848	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,203	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	11,197	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	22,702	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	22,702	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/8/2019 3:21 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)		12,889	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,889	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)		12,889	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)		5,169	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)		14,012,940	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)		14,012,940	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)		14,012,940	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)		1,087.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,619,737	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)		5,619,737	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/8/2019 3:21 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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)					3,676,945
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,296,682
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,191,455
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					462,840
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,654,295
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,642,387
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2006		Period: From 09/01/2017 To 08/31/2018		Worksheet D-1 Date/Time Prepared: 1/8/2019 3:21 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)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,970,878	14,012,940	0.212010	0	0	90.00
91.00	Nursing School cost	0	14,012,940	0.000000	0	0	91.00
92.00	Allied health cost	0	14,012,940	0.000000	0	0	92.00
93.00	All other Medical Education	0	14,012,940	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/8/2019 3:21 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			12,889 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			12,889 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)			12,889 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			2,779 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)			13,981,897 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)			13,981,897 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)			13,981,897 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)			1,084.79 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,014,631 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			3,014,631 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2006		Period: From 09/01/2017 To 08/31/2018		Worksheet D-1	
Title XIX		Hospital		Cost		Date/Time Prepared: 1/8/2019 3:21 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,660,897		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,675,528		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2006		Period: From 09/01/2017 To 08/31/2018		Worksheet D-1 Date/Time Prepared: 1/8/2019 3:21 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)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,970,878	13,981,897	0.212480	0	0	90.00
91.00	Nursing School cost	0	13,981,897	0.000000	0	0	91.00
92.00	Allied health cost	0	13,981,897	0.000000	0	0	92.00
93.00	All other Medical Education	0	13,981,897	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet D-2
Date/Time Prepared:
1/8/2019 3:21 pm

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V																																																																																																																															
	1.00	2.00	3.00	4.00	5.00																																																																																																																															
PART I - NOT IN APPROVED TEACHING PROGRAM																																																																																																																																				
Hospital Inpatient Routine Services:																																																																																																																																				
1.00 Total cost of services rendered	0.00	0				1.00																																																																																																																														
2.00 ADULTS & PEDIATRICS	0.00	0	12,889	0.00	0	2.00																																																																																																																														
3.00 INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00																																																																																																																														
4.00 CORONARY CARE UNIT						4.00																																																																																																																														
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7.00 OTHER SPECIAL CARE (SPECIFY)						7.00																																																																																																																														
8.00 NURSERY						8.00																																																																																																																														
9.00 Subtotal (sum of lines 2 through 8)	0.00	0				9.00																																																																																																																														
10.00 SUBPROVIDER - IPF						10.00																																																																																																																														
11.00 SUBPROVIDER - IRF						11.00																																																																																																																														
12.00 SUBPROVIDER						12.00																																																																																																																														
13.00 SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00																																																																																																																														
14.00 NURSING FACILITY						14.00																																																																																																																														
15.00 OTHER LONG TERM CARE						15.00																																																																																																																														
16.00 HOME HEALTH AGENCY						16.00																																																																																																																														
17.00 CMHC						17.00																																																																																																																														
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00																																																																																																																														
19.00 HOSPICE						19.00																																																																																																																														
20.00 Subtotal (sum of lines 9 through 19)	0.00	0				20.00																																																																																																																														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th></th> <th></th> <th>Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)</th> <th>Ratio of Cost to Charges (col. 2 ÷ col. 3)</th> <th>Titles V and XIX Outpatient and Title XVIII Part B Charges Title V</th> <th></th> </tr> <tr> <th></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> <th></th> </tr> </thead> <tbody> <tr> <td colspan="7">Hospital Outpatient Services:</td> </tr> <tr> <td>21.00 RURAL HEALTH CLINIC</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>21.00</td> </tr> <tr> <td>22.00 FEDERALLY QUALIFIED HEALTH CENTER CLINIC</td> <td>0.00</td> <td>0</td> <td>0</td> <td>0.000000</td> <td>0</td> <td>22.00</td> </tr> <tr> <td>23.00 CLINIC</td> <td>0.00</td> <td>0</td> <td>0</td> <td>0.000000</td> <td>0</td> <td>23.00</td> </tr> <tr> <td>24.00 EMERGENCY</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>24.00</td> </tr> <tr> <td>25.00 OBSERVATION BEDS (NON-DISTINCT PART)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>25.00</td> </tr> <tr> <td>26.00 OTHER OUTPATIENT SERVICE COST CENTER</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>26.00</td> </tr> <tr> <td>27.00 Subtotal (sum of lines 21 through 26)</td> <td>0.00</td> <td>0</td> <td></td> <td></td> <td></td> <td>27.00</td> </tr> <tr> <td>28.00 Total (sum of lines 20 and 27)</td> <td>0.00</td> <td>0</td> <td></td> <td></td> <td></td> <td>28.00</td> </tr> </tbody> </table>							Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V			1.00	2.00	3.00	4.00	5.00		Hospital Outpatient Services:							21.00 RURAL HEALTH CLINIC						21.00	22.00 FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0.00	0	0	0.000000	0	22.00	23.00 CLINIC	0.00	0	0	0.000000	0	23.00	24.00 EMERGENCY						24.00	25.00 OBSERVATION BEDS (NON-DISTINCT PART)						25.00	26.00 OTHER OUTPATIENT SERVICE COST CENTER						26.00	27.00 Subtotal (sum of lines 21 through 26)	0.00	0				27.00	28.00 Total (sum of lines 20 and 27)	0.00	0				28.00																																																	
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Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)																																																																																																																															
	1.00	2.00	3.00	4.00	5.00																																																																																																																															
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)																																																																																																																																				
Hospital Inpatient Routine Services:																																																																																																																																				
29.00 ADULTS & PEDIATRICS	0	0	0	12,889	0.00	29.00																																																																																																																														
30.00 Swing Bed - SNF				0	0.00	30.00																																																																																																																														
31.00 Swing Bed - NF				0		31.00																																																																																																																														
32.00 INTENSIVE CARE UNIT	0			0	0.00	32.00																																																																																																																														
33.00 CORONARY CARE UNIT						33.00																																																																																																																														
34.00 BURN INTENSIVE CARE UNIT						34.00																																																																																																																														
35.00 SURGICAL INTENSIVE CARE UNIT						35.00																																																																																																																														
36.00 OTHER SPECIAL CARE (SPECIFY)						36.00																																																																																																																														
37.00 Subtotal (sum of lines 29, and 32 through 36)	0			0		37.00																																																																																																																														
38.00 SUBPROVIDER - IPF						38.00																																																																																																																														
39.00 SUBPROVIDER - IRF						39.00																																																																																																																														
40.00 SUBPROVIDER						40.00																																																																																																																														
41.00 SKILLED NURSING FACILITY	0			0	0.00	41.00																																																																																																																														
42.00 Total (sum of lines 37 through 41)	0			0		42.00																																																																																																																														

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet D-2

Date/Time Prepared:
1/8/2019 3:21 pm

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

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS	Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D-2 Date/Time Prepared: 1/8/2019 3:21 pm
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Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)		
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX					
	6.00	7.00					
PART I - NOT IN APPROVED TEACHING PROGRAM							
1.00	Total cost of services rendered					1.00	
Hospital Inpatient Routine Services:							
2.00	ADULTS & PEDIATRICS	5,169	2,779	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)						20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost			
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
Hospital Outpatient Services:							
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	0	27.00
28.00	Total (sum of lines 20 and 27)						28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents			
		6.00	7.00	11.00			
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)							
Hospital Inpatient Routine Services:							
29.00	ADULTS & PEDIATRICS	0	0	0			29.00
30.00	Swing Bed - SNF	0	0				30.00
31.00	Swing Bed - NF						31.00
32.00	INTENSIVE CARE UNIT	0	0	0			32.00
33.00	CORONARY CARE UNIT						33.00
34.00	BURN INTENSIVE CARE UNIT						34.00
35.00	SURGICAL INTENSIVE CARE UNIT						35.00
36.00	OTHER SPECIAL CARE (SPECIFY)						36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)		0	0			37.00
38.00	SUBPROVIDER - IPF						38.00
39.00	SUBPROVIDER - IRF						39.00
40.00	SUBPROVIDER						40.00
41.00	SKILLED NURSING FACILITY	0	0	0			41.00
42.00	Total (sum of lines 37 through 41)		0	0			42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet D-2

Date/Time Prepared:
1/8/2019 3:21 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D-3 Date/Time Prepared: 1/8/2019 3:21 pm	
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		12,876,706		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.741037	133,497	98,926	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.326744	556,076	181,694	54.00
60.00	06000 LABORATORY	0.127358	2,866,196	365,033	60.00
65.00	06500 RESPIRATORY THERAPY	0.159005	4,892,273	777,896	65.00
66.00	06600 PHYSICAL THERAPY	0.453594	1,552,779	704,331	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.790845	256,789	203,080	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.138722	7,849,859	1,088,948	73.00
74.00	07400 RENAL DIALYSIS	0.444901	577,739	257,037	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		18,685,208	3,676,945	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		18,685,208		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet D-3 Date/Time Prepared: 1/8/2019 3:21 pm	
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		6,898,136		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.741037	60,976	45,185	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.326744	278,221	90,907	54.00
60.00	06000 LABORATORY	0.126532	1,317,520	166,708	60.00
65.00	06500 RESPIRATORY THERAPY	0.159005	2,209,013	351,244	65.00
66.00	06600 PHYSICAL THERAPY	0.453594	720,686	326,899	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.790845	145,642	115,180	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.138722	3,491,114	484,294	73.00
74.00	07400 RENAL DIALYSIS	0.444901	180,895	80,480	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		8,404,067	1,660,897	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		8,404,067		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part B Date/Time Prepared: 1/8/2019 3:21 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		22,702	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		22,702	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		72,738	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)		72,738	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)		72,738	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		50,036	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		22,702	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		14,548	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	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)		8,154	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)		8,154	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		8,154	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		8,154	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
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		8,154	40.00
40.01	Sequestration adjustment (see instructions)		163	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		8,608	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-617	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: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet E-1
Part I
Date/Time Prepared:
1/8/2019 3:21 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		8,540,062		8,608	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,540,062		8,608	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		286,933		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		617	6.02	
7.00	Total Medicare program liability (see instructions)		8,826,995		7,991	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part IV Date/Time Prepared: 1/8/2019 3:21 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		8,738,437	1.00
1.01	Full standard payment amount		7,295,433	1.01
1.02	Short stay outlier standard payment amount		1,244,575	1.02
1.03	Site neutral payment amount - Cost		0	1.03
1.04	Site neutral payment amount - IPPS comparable		198,429	1.04
2.00	Outlier Payments		626,851	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		9,365,288	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		9,365,288	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		9,365,288	9.00
10.00	Deductibles		15,984	10.00
11.00	Subtotal (line 9 minus line 10)		9,349,304	11.00
12.00	Coinsurance		492,695	12.00
13.00	Subtotal (line 11 minus line 12)		8,856,609	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		231,583	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		150,529	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		178,870	16.00
17.00	Subtotal (sum of lines 13 and 15)		9,007,138	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Demonstration payment adjustment amount before sequestration		0	21.99
22.00	Total amount payable to the provider (see instructions)		9,007,138	22.00
22.01	Sequestration adjustment (see instructions)		180,143	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		8,540,062	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)		286,933	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		9,794	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)		626,851	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2006	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 1/8/2019 3:21 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		4,675,528		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		4,675,528	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4,675,528	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		6,898,136		8.00
9.00	Ancillary service charges		8,404,067	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		15,302,203	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		15,302,203	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		10,626,675	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		4,675,528	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		4,675,528	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4,675,528	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		4,675,528	0	36.00
37.00	OTHER ADJUSTMENTS		0		37.00
37.01	OTHER ADJUSTMENTS		0		37.01
38.00	Subtotal (line 36 ± line 37)		4,675,528	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		4,675,528	0	40.00
41.00	Interim payments		3,583,841		41.00
42.00	Balance due provider/program (line 40 minus line 41)		1,091,687		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0		43.00

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

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet G
Date/Time Prepared:
1/8/2019 3:21 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	92,987	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	4,617,583	0	0	0	4.00
5.00	Other receivable	-443	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,396,749	0	0	0	6.00
7.00	Inventory	210,087	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,523,465	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	8,849,774	0	0	0	17.00
18.00	Accumulated depreciation	-8,377,997	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,999,902	0	0	0	23.00
24.00	Accumulated depreciation	-3,436,180	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,035,499	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,500	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,500	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	4,562,464	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	501,503	0	0	0	37.00
38.00	Salaries, wages, and fees payable	275,343	0	0	0	38.00
39.00	Payroll taxes payable	7,480	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	523,998	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,308,324	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-46,468,877	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-46,468,877	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-45,160,553	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	49,723,017				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)	49,723,017	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	4,562,464	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet G-1

Date/Time Prepared:
1/8/2019 3:21 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		51,806,782		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,067,146			2.00
3.00	Total (sum of line 1 and line 2)		49,739,636		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	0		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)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		49,739,636		0	11.00
12.00	Deductions (debit adjustments)	0		0		12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	16,619		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)		16,619		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,723,017		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)		0			4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)		0			12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/8/2019 3:21 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	32,198,049		32,198,049	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	32,198,049		32,198,049	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	32,198,049		32,198,049	17.00
18.00	Ancillary services	45,610,756	242,498	45,853,254	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	77,808,805	242,498	78,051,303	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,191,160		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)		25,191,160		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-2006

Period:
From 09/01/2017
To 08/31/2018

Worksheet G-3

Date/Time Prepared:
1/8/2019 3:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	78,051,303	1.00
2.00	Less contractual allowances and discounts on patients' accounts	55,035,777	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,015,526	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,191,160	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,175,634	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	2,378	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	20,541	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	832	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	84,737	24.00
25.00	Total other income (sum of lines 6-24)	108,488	25.00
26.00	Total (line 5 plus line 25)	-2,067,146	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,067,146	29.00