

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: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet S Parts I-III Date/Time Prepared: 8/18/2017 2:59 pm
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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: 8/18/2017 Time: 2:59 pm

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL OF CARBONDALE (14-0164) for the cost reporting period beginning 04/01/2016 and ending 03/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	216,017	69,490	-8,902	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		50,401		0	10.00
200.00 Total	0	216,017	119,891	-8,902	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0164		Period: From 04/01/2016 To 03/31/2017		Worksheet S-2 Part I Date/Time Prepared: 8/18/2017 2:58 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 405 W. JACKSON ST.			PO Box:						1.00	
2.00	City: CARBONDALE			State: IL		Zip Code: 62901		County:		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		MEMORIAL HOSPITAL OF CARBONDALE	140164	16060	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		WEST FRANKFORT FAMILY MEDICINE	143454	99914		11/01/1999	N	O	N	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)						04/01/2016	03/31/2017		20.00	
21.00	Type of Control (see instructions)						2			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							1	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		8,421	633	0	0	481	1,098		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0	0	0	0	0			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/18/2017 2:58 pm			
		Urban/Rural S	Date of Geogr				
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00		
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0			37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)				37.01		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.				38.00		
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N	39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N	40.00		
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	Y	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 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.	Y			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.20	
					1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				Y	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	
	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)	SOUTHERN ILLINOIS FAMILY MEDICINE	1350	9.77	4.69	0.675657	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	SOUTHERN ILLINOIS FAMILY MEDICINE	1350	11.20	5.44	0.673077
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
					1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
					1.00	2.00	3.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	3,999,989		0		0	
					1.00		2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/18/2017 2:58 pm			
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H124	140.00			
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: SO ILL HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 1239 E. MAIN STREET	PO Box: 3988				142.00	
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
				1.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	N	145.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00			
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0		168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.25		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/18/2017 2:58 pm
		Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	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)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0164		Period: From 04/01/2016 To 03/31/2017		Worksheet S-2 Part II Date/Time Prepared: 8/18/2017 2:58 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				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					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	06/23/2017	Y	06/23/2017		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: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part II Date/Time Prepared: 8/18/2017 2:58 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		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SO ILL HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200	LUANNE.WARREN@SIH.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part II Date/Time Prepared: 8/18/2017 2:58 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.	REIMB DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part IX Date/Time Prepared: 8/18/2017 2:58 pm
		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FOHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
8/18/2017 2:58 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	133	48,545	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)		133	48,545	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	13	4,745	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 NEONATAL INTENSIVE CARE UNIT	35.00	13	4,745	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		159	58,035	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		159				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)		9	3,285			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
8/18/2017 2:58 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)	12,490	5,067	26,918			1.00
2.00 HMO and other (see instructions)	2,320	1,579				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)	12,490	5,067	26,918			7.00
8.00 INTENSIVE CARE UNIT	2,108	489	4,612			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 NEONATAL INTENSIVE CARE UNIT	0	1,306	2,222			12.00
13.00 NURSERY		1,423	2,795			13.00
14.00 Total (see instructions)	14,598	8,285	36,547	13.31	1,116.70	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	3,304	3,439	11,772	3.33	10.84	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)				16.64	1,127.54	27.00
28.00 Observation Bed Days		470	3,492			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	769	1,789			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			605			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet S-3
Part I
Date/Time Prepared:
8/18/2017 2:58 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	3,785	2,548	10,580	1.00
2.00 HMO and other (see instructions)			608	634		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 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,785	2,548	10,580	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet S-3
Part II
Date/Time Prepared:
8/18/2017 2:58 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 II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	64,706,377	0	64,706,377	2,345,275.02	27.59
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		221,627	0	221,627	4,604.34	48.13
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		365,743	0	365,743	22,549.33	16.22
7.00	Interns & residents (in an approved program)	21.00	1,095,789	0	1,095,789	40,215.50	27.25
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	0	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,705,132	0	1,705,132	39,036.72	43.68
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		384,637	0	384,637	2,210.00	174.04
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		9,745,840	0	9,745,840	294,628.84	33.08
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)		15,767,258	0	15,767,258		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		0	0	0		
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		55,462	0	55,462		
24.00	Wage-related costs (RHC/FQHC)		95,834	0	95,834		
25.00	Interns & residents (in an approved program)		274,221	0	274,221		
25.50	Home office wage-related		3,505,438	0	3,505,438		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	240,464	0	240,464	8,286.42	29.02
27.00	Administrative & General	5.00	6,433,045	0	6,433,045	192,598.34	33.40

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet S-3
Part II
Date/Time Prepared:
8/18/2017 2:58 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	1,758,371	0	1,758,371	4,393.58	400.21	28.00
29.00	Maintenance & Repairs	623,686	0	623,686	30,318.59	20.57	29.00
30.00	Operation of Plant	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	76,169	0	76,169	5,932.34	12.84	31.00
32.00	Housekeeping	1,385,384	0	1,385,384	111,435.58	12.43	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	1,393,445	-1,041,533	351,912	23,555.14	14.94	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	1,041,533	1,041,533	69,732.55	14.94	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	878,633	0	878,633	20,027.26	43.87	38.00
39.00	Central Services and Supply	313,522	0	313,522	22,645.39	13.84	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	552,247	0	552,247	32,736.57	16.87	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet S-3
Part III
Date/Time Prepared:
8/18/2017 2:58 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)	64,781,589	0	64,781,589	2,282,299.43	28.38	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	64,781,589	0	64,781,589	2,282,299.43	28.38	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,835,609	0	11,835,609	335,875.56	35.24	4.00
5.00	Subtotal wage-related costs (see inst.)	19,272,696	0	19,272,696	0.00	29.75	5.00
6.00	Total (sum of lines 3 thru 5)	95,889,894	0	95,889,894	2,618,174.99	36.62	6.00
7.00	Total overhead cost (see instructions)	13,654,966	0	13,654,966	521,661.76	26.18	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 8/18/2017 2:58 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,006,415	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		1,480	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)		8,415,942	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		170,525	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		40,520	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)		198,871	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		673,940	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		655,595	16.00
TAXES				
17.00	FICA-Employers Portion Only		4,669,203	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		35,877	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		145,009	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		179,398	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		16,192,775	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: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet S-3 Part V Date/Time Prepared: 8/18/2017 2:58 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,705,132	16,192,775	1.00
2.00	Hospital	1,705,132	16,192,775	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0164 Component CCN: 14-3454		Period: From 04/01/2016 To 03/31/2017		Worksheet S-8 Date/Time Prepared: 8/18/2017 2:58 pm	
		RHC I		Cost			
				1.00			
1.00	Clinic Address and Identification Street	2553 KEN GRAY BLVD				1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	City, State, ZIP Code, County	WEST FRANKFORT		IL		62896	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
		Grant Award		Date			
		1.00		2.00			
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00	Facility hours of operations (1) Clinic						
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0		13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number					14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
		County		4.00			
2.00	City, State, ZIP Code, County	FRANKLIN				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	Facility hours of operations (1) Clinic						

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0164 Component CCN: 14-3454		Period: From 04/01/2016 To 03/31/2017		Worksheet S-8 Date/Time Prepared: 8/18/2017 2:58 pm		
				RHC I		Cost		
		Friday		Saturday				
		from	to	from	to			
		11.00	12.00	13.00	14.00			
11.00	Facility hours of operations (1) Clinic							11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet S-10 Date/Time Prepared: 8/18/2017 2:58 pm
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			1.00			
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.230721	1.00		
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		22,791,632	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		11,819,088	5.00		
6.00	Medicaid charges		185,836,682	6.00		
7.00	Medicaid cost (line 1 times line 6)		42,876,425	7.00		
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		8,265,705	8.00		
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP		0	9.00		
10.00	Stand-alone CHIP charges		0	10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00		
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00		
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00		
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00		
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00		
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00		
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00		
18.00	Government grants, appropriations or transfers for support of hospital operations		564,652	18.00		
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		8,265,705	19.00		
			Uninsured patients	Insured patients		
			1.00	2.00		
20.00	Charity care charges for the entire facility (see instructions)		5,617,785	2,229,384	7,847,169	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)		1,296,141	514,366	1,810,507	21.00
22.00	Partial payment by patients approved for charity care		24,454	35,734	60,188	22.00
23.00	Cost of charity care (line 21 minus line 22)		1,271,687	478,632	1,750,319	23.00
			1.00			
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0			25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		14,298,417			26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,068,192			27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		13,230,225			28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,052,491			29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,802,810			30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		13,068,515			31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		6,619,376	6,619,376	284,097	6,903,473	1.00
2.00	00200		7,181,710	7,181,710	125,574	7,307,284	2.00
4.00	00400						
		240,464	20,336,688	20,577,152	0	20,577,152	4.00
5.01	00550	0	0	0	0	0	5.01
5.02	00560	372,904	134,228	507,132	0	507,132	5.02
5.03	00580	642,648	51,093	693,741	0	693,741	5.03
5.04	00590	5,417,493	14,522,204	19,939,697	-1,046	19,938,651	5.04
6.00	00600	623,686	1,876,917	2,500,603	0	2,500,603	6.00
8.00	00800	76,169	1,329,346	1,405,515	0	1,405,515	8.00
9.00	00900	1,385,384	458,998	1,844,382	0	1,844,382	9.00
10.00	01000	1,393,445	1,282,983	2,676,428	-2,020,058	656,370	10.00
11.00	01100	0	0	0	2,000,501	2,000,501	11.00
13.00	01300	878,633	75,547	954,180	-1,374	952,806	13.00
14.00	01400	313,522	128,606	442,128	-25,398	416,730	14.00
16.00	01600	552,247	84,447	636,694	0	636,694	16.00
19.00	01900	0	0	0	4,262,957	4,262,957	19.00
21.00	02100	1,095,789	0	1,095,789	0	1,095,789	21.00
22.00	02200	0	1,398,924	1,398,924	0	1,398,924	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	14,195,436	9,204,697	23,400,133	-138,406	23,261,727	30.00
31.00	03100	3,657,272	995,089	4,652,361	-72,463	4,579,898	31.00
35.00	02060	929,342	114,639	1,043,981	-38	1,043,943	35.00
43.00	04300	0	181,959	181,959	-5,852	176,107	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,922,504	19,489,374	23,411,878	-12,215,946	11,195,932	50.00
50.01	05001	1,269,922	861,402	2,131,324	-2,131,324	0	50.01
51.00	05100	744,195	28,529	772,724	-5,733	766,991	51.00
52.00	05200	3,400,989	579,388	3,980,377	-89,947	3,890,430	52.00
53.00	05300	637,969	4,971,288	5,609,257	-4,434,674	1,174,583	53.00
54.00	05400	2,666,922	1,976,179	4,643,101	-900,207	3,742,894	54.00
54.01	03480	843,357	1,818,584	2,661,941	-15,527	2,646,414	54.01
54.02	03440	599,074	591,256	1,190,330	-5,529	1,184,801	54.02
56.00	05600	256,435	1,011,275	1,267,710	155,054	1,422,764	56.00
58.00	05800	279,365	302,899	582,264	-98,379	483,885	58.00
59.00	05900	3,677,041	13,702,913	17,379,954	-10,290,009	7,089,945	59.00
60.00	06000	2,274,125	5,477,706	7,751,831	-6,892	7,744,939	60.00
64.00	06400	551,693	339,843	891,536	-43,616	847,920	64.00
65.00	06500	1,275,796	331,778	1,607,574	-116,322	1,491,252	65.00
66.00	06600	2,353,650	773,100	3,126,750	-1,035	3,125,715	66.00
69.00	06900	1,216,798	7,778,579	8,995,377	-611,150	8,384,227	69.00
70.00	07000	78,796	98,308	177,104	-6,485	170,619	70.00
71.00	07100	0	0	0	9,673,255	9,673,255	71.00
72.00	07200	0	0	0	16,171,314	16,171,314	72.00
73.00	07300	2,734,345	16,751,437	19,485,782	1,043,523	20,529,305	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	365,743	1,072,516	1,438,259	-12,314	1,425,945	88.00
91.00	09100	3,783,224	4,845,647	8,628,871	-56,880	8,571,991	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		4,209,846	4,209,846	-409,671	3,800,175	113.00
118.00		64,706,377	152,989,298	217,695,675	0	217,695,675	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	102,145	102,145	0	102,145	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
200.00		64,706,377	153,091,443	217,797,820	0	217,797,820	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A
Date/Time Prepared:
8/18/2017 2:58 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	-366,316	6,537,157	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,758,025	13,065,309	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	920,152	21,497,304	4.00
5.01	00550	DATA PROCESSING	6,971,436	6,971,436	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-25,479	481,653	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,818,224	4,511,965	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	6,266,312	26,204,963	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	2,500,603	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,405,515	8.00
9.00	00900	HOUSEKEEPING	-80	1,844,302	9.00
10.00	01000	DIETARY	0	656,370	10.00
11.00	01100	CAFETERIA	-1,239,124	761,377	11.00
13.00	01300	NURSING ADMINISTRATION	0	952,806	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	416,730	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-104,892	531,802	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-4,262,957	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,095,789	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-919	1,398,005	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,057,077	18,204,650	30.00
31.00	03100	INTENSIVE CARE UNIT	-16,412	4,563,486	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-600	1,043,343	35.00
43.00	04300	NURSERY	0	176,107	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-174,921	11,021,011	50.00
50.01	05001	SAME DAY SURGERY	0	0	50.01
51.00	05100	RECOVERY ROOM	0	766,991	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-69,744	3,820,686	52.00
53.00	05300	ANESTHESIOLOGY	0	1,174,583	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-9,383	3,733,511	54.00
54.01	03480	ONCOLOGY	-682,751	1,963,663	54.01
54.02	03440	MAMMOGRAPHY	-46,316	1,138,485	54.02
56.00	05600	RADIOISOTOPE	0	1,422,764	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	483,885	58.00
59.00	05900	CARDIAC CATHETERIZATION	-110,720	6,979,225	59.00
60.00	06000	LABORATORY	-241,091	7,503,848	60.00
64.00	06400	INTRAVENOUS THERAPY	-17,845	830,075	64.00
65.00	06500	RESPIRATORY THERAPY	-4,543	1,486,709	65.00
66.00	06600	PHYSICAL THERAPY	-75,983	3,049,732	66.00
69.00	06900	ELECTROCARDIOLOGY	-212,926	8,171,301	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-6,200	164,419	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,673,255	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,171,314	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,529,305	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-45,615	1,380,330	88.00
91.00	09100	EMERGENCY	-3,951,165	4,620,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-3,800,175	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,210,915	220,906,590	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	102,145	192.00
192.01	19201	FAMILY PRACTICE	0	0	192.01
192.02	19202	UNUSED SPACE	0	0	192.02
200.00		TOTAL (SUM OF LINES 118-199)	3,210,915	221,008,735	200.00

COST CENTERS USED IN COST REPORT	Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet Non-CMS W Date/Time Prepared: 8/18/2017 2:58 pm
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Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01 DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02 PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00 MAINTENANCE & REPAIRS	00600		6.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
19.00 NONPHYSICIAN ANESTHETISTS	01900		19.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	02100		21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	02200		22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
35.00 NEONATAL INTENSIVE CARE UNIT	02060	NEONATAL INTENSIVE CARE UNIT	35.00
43.00 NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
50.01 SAME DAY SURGERY	05001		50.01
51.00 RECOVERY ROOM	05100		51.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01 ONCOLOGY	03480	ONCOLOGY	54.01
54.02 MAMMOGRAPHY	03440	MAMMOGRAPHY	54.02
56.00 RADIOISOTOPE	05600		56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
64.00 INTRAVENOUS THERAPY	06400		64.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
69.00 ELECTROCARDIOLOGY	06900		69.00
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	08800		88.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01 FAMILY PRACTICE	19201		192.01
192.02 UNUSED SPACE	19202		192.02
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-6
Date/Time Prepared:
8/18/2017 2:58 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - DIETARY RECLASS						
1.00	CAFETERIA	11.00	1,041,533	958,968	1.00	
	TOTALS		1,041,533	958,968		
B - NUTRITIONAL PRODUCT RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	453,600	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
	TOTALS		0	453,600		
C - MEDICAL SUPPLY RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	25,844,569	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
	TOTALS		0	25,844,569		
D - SAME DAY SURGERY RECLASS						
1.00	OPERATING ROOM	50.00	1,269,922	861,402	1.00	
	TOTALS		1,269,922	861,402		
E - INTEREST RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	284,097	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	125,574	2.00	
	TOTALS		0	409,671		
F - IMPLANTABLE DEVICE RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	16,171,314	1.00	
	TOTALS		0	16,171,314		
G - CRNA RECLASS						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	4,262,957	1.00	
	TOTALS		0	4,262,957		
H - CONTRAST DRUG RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	589,923	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
	TOTALS		0	589,923		

RECLASSIFICATIONS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-6
Date/Time Prepared:
8/18/2017 2:58 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
I - ISOTOPE RECLASS					
1.00	RADIOISOTOPE	56.00	0	166,344	1.00
TOTALS			0	166,344	
500.00	Grand Total: Increases		2,311,455	49,718,748	500.00

RECLASSIFICATIONS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-6
Date/Time Prepared:
8/18/2017 2:58 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - DIETARY RECLASS							
1.00	DIETARY	10.00	1,041,533	958,968	0		1.00
	TOTALS		1,041,533	958,968			
B - NUTRITIONAL PRODUCT RECLASS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	731	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	135,207	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	33,292	0		3.00
4.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	36	0		4.00
5.00	NURSERY	43.00	0	5,838	0		5.00
6.00	OPERATING ROOM	50.00	0	43,831	0		6.00
7.00	RECOVERY ROOM	51.00	0	5,658	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	37,019	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	51,288	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,808	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	27,970	0		11.00
12.00	RADIOISOTOPE	56.00	0	726	0		12.00
13.00	LABORATORY	60.00	0	193	0		13.00
14.00	INTRAVENOUS THERAPY	64.00	0	32,679	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	2,409	0		15.00
16.00	EMERGENCY	91.00	0	50,116	0		16.00
17.00	MAMMOGRAPHY	54.02	0	1,242	0		17.00
18.00	DIETARY	10.00	0	19,557	0		18.00
	TOTALS		0	453,600			
C - MEDICAL SUPPLY RECLASS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	24,667	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,199	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	39,171	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	1,374	0		4.00
5.00	NURSERY	43.00	0	14	0		5.00
6.00	OPERATING ROOM	50.00	0	14,293,488	0		6.00
7.00	RECOVERY ROOM	51.00	0	75	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	52,928	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	120,429	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	826,588	0		10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	16,685	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	10,171,028	0		12.00
13.00	LABORATORY	60.00	0	6,699	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	116,322	0		14.00
15.00	EMERGENCY	91.00	0	6,764	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	102,941	0		16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,485	0		17.00
18.00	MAMMOGRAPHY	54.02	0	4,287	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	1,035	0		19.00
20.00	ONCOLOGY	54.01	0	15,527	0		20.00
21.00	RURAL HEALTH CLINIC	88.00	0	12,314	0		21.00
22.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,046	0		22.00
23.00	INTRAVENOUS THERAPY	64.00	0	10,937	0		23.00
24.00	RADIOISOTOPE	56.00	0	10,564	0		24.00
25.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	2	0		25.00
	TOTALS		0	25,844,569			
D - SAME DAY SURGERY RECLASS							
1.00	SAME DAY SURGERY	50.01	1,269,922	861,402	0		1.00
	TOTALS		1,269,922	861,402			
E - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	409,671	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	409,671			
F - IMPLANTABLE DEVICE RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16,171,314	0		1.00
	TOTALS		0	16,171,314			
G - CRNA RECLASS							
1.00	ANESTHESIOLOGY	53.00	0	4,262,957	0		1.00
	TOTALS		0	4,262,957			
H - CONTRAST DRUG RECLASS							
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	81,694	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	339,456	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	67,811	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	91,011	0		4.00
5.00	OPERATING ROOM	50.00	0	9,951	0		5.00
	TOTALS		0	589,923			

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-6
Date/Time Prepared:
8/18/2017 2:58 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	I - ISOTOPE RECLASS					
1.00	ELECTROCARDIOLOGY	69.00	0	166,344	0	1.00
	TOTALS		0	166,344		
500.00	Grand Total: Decreases		2,311,455	49,718,748		500.00

RECLASSIFICATIONS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/18/2017 2:58 pm

Increases				Decreases					
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
A - DIETARY RECLASS									
1.00	CAFETERIA	11.00	1,041,533	958,968	DIETARY	10.00	1,041,533	958,968	1.00
	TOTALS		1,041,533	958,968	TOTALS		1,041,533	958,968	
B - NUTRITIONAL PRODUCT RECLASS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	453,600	CENTRAL SERVICES & SUPPLY	14.00	0	731	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	135,207	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	33,292	3.00
4.00		0.00	0	0	NEONATAL INTENSIVE CARE UNIT	35.00	0	36	4.00
5.00		0.00	0	0	NURSERY	43.00	0	5,838	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	43,831	6.00
7.00		0.00	0	0	RECOVERY ROOM	51.00	0	5,658	7.00
8.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	37,019	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	51,288	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	5,808	10.00
11.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	27,970	11.00
12.00		0.00	0	0	RADIOISOTOPE	56.00	0	726	12.00
13.00		0.00	0	0	LABORATORY	60.00	0	193	13.00
14.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	32,679	14.00
15.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	2,409	15.00
16.00		0.00	0	0	EMERGENCY	91.00	0	50,116	16.00
17.00		0.00	0	0	MAMMOGRAPHY	54.02	0	1,242	17.00
18.00		0.00	0	0	DIETARY	10.00	0	19,557	18.00
	TOTALS		0	453,600	TOTALS		0	453,600	
C - MEDICAL SUPPLY RECLASS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	25,844,569	CENTRAL SERVICES & SUPPLY	14.00	0	24,667	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	3,199	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	39,171	3.00
4.00		0.00	0	0	NURSING ADMINISTRATION	13.00	0	1,374	4.00
5.00		0.00	0	0	NURSERY	43.00	0	14	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	14,293,488	6.00
7.00		0.00	0	0	RECOVERY ROOM	51.00	0	75	7.00
8.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	52,928	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	120,429	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	826,588	10.00
11.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	16,685	11.00
12.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	10,171,028	12.00
13.00		0.00	0	0	LABORATORY	60.00	0	6,699	13.00
14.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	116,322	14.00
15.00		0.00	0	0	EMERGENCY	91.00	0	6,764	15.00
16.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	102,941	16.00
17.00		0.00	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	6,485	17.00
18.00		0.00	0	0	MAMMOGRAPHY	54.02	0	4,287	18.00
19.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	1,035	19.00
20.00		0.00	0	0	ONCOLOGY	54.01	0	15,527	20.00
21.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	12,314	21.00
22.00		0.00	0	0	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,046	22.00
23.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	10,937	23.00
24.00		0.00	0	0	RADIOISOTOPE	56.00	0	10,564	24.00
25.00		0.00	0	0	NEONATAL INTENSIVE CARE UNIT	35.00	0	2	25.00
	TOTALS		0	25,844,569	TOTALS		0	25,844,569	
D - SAME DAY SURGERY RECLASS									
1.00	OPERATING ROOM	50.00	1,269,922	861,402	SAME DAY SURGERY	50.01	1,269,922	861,402	1.00
	TOTALS		1,269,922	861,402	TOTALS		1,269,922	861,402	
E - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	284,097	INTEREST EXPENSE	113.00	0	409,671	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	125,574		0.00	0	0	2.00
	TOTALS		0	409,671	TOTALS		0	409,671	
F - IMPLANTABLE DEVICE RECLASS									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	16,171,314	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16,171,314	1.00
	TOTALS		0	16,171,314	TOTALS		0	16,171,314	

RECLASSIFICATIONS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/18/2017 2:58 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
G - CRNA RECLASS									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	4,262,957	ANESTHESIOLOGY	53.00	0	4,262,957	1.00
	TOTALS		0	4,262,957	TOTALS		0	4,262,957	
H - CONTRAST DRUG RECLASS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	589,923	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	81,694	1.00
2.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	339,456	2.00
3.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	67,811	3.00
4.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	91,011	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	9,951	5.00
	TOTALS		0	589,923	TOTALS		0	589,923	
I - ISOTOPE RECLASS									
1.00	RADIOISOTOPE	56.00	0	166,344	ELECTROCARDIOLOGY	69.00	0	166,344	1.00
	TOTALS		0	166,344	TOTALS		0	166,344	
500.00	Grand Total : Increases		2,311,455	49,718,748	Grand Total : Decreases		2,311,455	49,718,748	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-7
Part I
Date/Time Prepared:
8/18/2017 2:58 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,880,998	121,000	0	121,000	0	1.00
2.00	Land Improvements	5,719,625	836,451	0	836,451	657,867	2.00
3.00	Buildings and Fixtures	149,704,681	20,269,155	0	20,269,155	11,187,768	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	70,006,574	12,813,607	0	12,813,607	6,933,002	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	232,311,878	34,040,213	0	34,040,213	18,778,637	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	232,311,878	34,040,213	0	34,040,213	18,778,637	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,001,998	0				1.00
2.00	Land Improvements	5,898,209	0				2.00
3.00	Buildings and Fixtures	158,786,068	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	75,887,179	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	247,573,454	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	247,573,454	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-7
Part II
Date/Time Prepared:
8/18/2017 2:58 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	6,619,376	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,181,710	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,801,086	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	6,619,376				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,181,710				2.00
3.00	Total (sum of lines 1-2)	0	13,801,086				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-7
Part III
Date/Time Prepared:
8/18/2017 2:58 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	171,686,275	0	171,686,275	0.693476	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	75,887,179	0	75,887,179	0.306524	0	2.00
3.00	Total (sum of lines 1-2)	247,573,454	0	247,573,454	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	6,537,157	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,065,309	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,602,466	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	6,537,157	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	13,065,309	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	19,602,466	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-11,037,050				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	36,902,187				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,220,480	CAFETERIA		11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-75,025	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-18,644	CAFETERIA		11.00	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	A	-4,262,957	NONPHYSICIAN ANESTHETISTS		19.00	0	28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 EMPLOYEE OUTPATIENT PAYMENTS	B	-4,029,962	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.00

33.01	DEBT FORGIVENESS	A	-140,012	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		5.04	0	33.01			
				Basis/Code (2)	Amount				Cost Center	Line #	Wkst. A-7 Ref.
				OTHER ADMINISTRATIVE AND GENERAL							
33.02	TELEVISION AND RADIO SERVICES	A	-2,873	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.02			
33.03	INTEREST INCOME UNRESTRICTED	B	-1,679,897	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.03			
33.04	LOSS ON 1994 BONDS	A	112,151	CAP REL COSTS-BLDG & FIXT		1.00	9	33.04			
33.05	LOSS ON 1994 BONDS	A	96,192	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.05			
33.06	FUNDED DEPRECIATION	A	-4,976	CAP REL COSTS-BLDG & FIXT		1.00	9	33.06			
33.07	NONALLOWABLE BOND EXPENSE	A	-3,800,175	INTEREST EXPENSE		113.00	0	33.07			
33.08	MISCELLANEOUS INCOME	B	-765	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.08			
33.09	SALE OF XRAY SILVER/FILM	B	-2,815	RADIOLOGY-DIAGNOSTIC		54.00	0	33.09			
33.10	OFFSET LOBBYING EXPENSES	A	-25,572	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.10			
33.11	PURCHASE DISCOUNT	B	-23,071	PURCHASING RECEIVING AND STORES		5.02	0	33.11			
33.12	LOSS ON 1991 BONDS	A	142,822	CAP REL COSTS-BLDG & FIXT		1.00	9	33.12			
33.13	LOSS ON 1991 BONDS	A	97,741	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.13			
33.14	LEASEHOLD REVENUE	B	-38,809	MAMMOGRAPHY		54.02	0	33.14			
33.15	VENDING MACHINE INCOME	B	-80	HOUSEKEEPING		9.00	0	33.15			
33.16	PATIENT'S GUEST LODGING EXPENSE	A	-66,721	CARDIAC CATHETERIZATION		59.00	0	33.16			
33.17	LEASEHOLD REVENUE	B	-836,854	CAP REL COSTS-BLDG & FIXT		1.00	9	33.17			
33.18	MEDICAID PROVIDER TAX	A	-6,803,247	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.18			
33.19	CABLE TV	A	-919	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00	0	33.19			
33.20	SALE OF MEDICAL RECORDS	B	-1,100	RURAL HEALTH CLINIC		88.00	0	33.20			
33.21	MISCELLANEOUS INCOME	B	-43,810	RURAL HEALTH CLINIC		88.00	0	33.21			
33.22	INTEREST INCOME UNRESTRICTED	B	-705	RURAL HEALTH CLINIC		88.00	0	33.22			
33.23	VENDING MACHINE INCOME	B	-1,018	ELECTROCARDIOLOGY		69.00	0	33.23			
33.24	DEPT. PROG REV RESP.	B	-4,543	RESPIRATORY THERAPY		65.00	0	33.24			
33.25	DEPT. PROG REV OP CARDIO	B	-4,050	ELECTROCARDIOLOGY		69.00	0	33.25			
33.26	CABLE TV	B	-2,408	PURCHASING RECEIVING AND STORES		5.02	0	33.26			
33.27	TRANSFER TO HERRIN DR. HATCHETT	A	-11,640	OPERATING ROOM		50.00	0	33.27			
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		3,210,915					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: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-8-1

Date/Time Prepared:
8/18/2017 2:58 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	220,541	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	5,566,965	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	4,950,114	0
4.00	5.01	DATA PROCESSING	HOME OFFICE	6,971,436	0
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	3,818,224	0
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	15,504,978	0
4.03	66.00	PHYSICAL THERAPY	RENT	72,145	148,128
4.04	5.04	OTHER ADMINISTRATIVE AND GEN	RENT	9,422	19,320
4.05	16.00	MEDICAL RECORDS & LIBRARY	RENT	21,361	51,228
4.06	54.00	RADIOLOGY-DIAGNOSTIC	RENT	4,904	11,472
4.07	60.00	LABORATORY	RENT	13,553	21,308
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			37,153,643	251,456

* 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	SIHS	100.00	SIHS	100.00	6.00
7.00	B	SIHE	100.00	SIHE	100.00	7.00
8.00	B	HSSI	100.00	HSSI	100.00	8.00
9.00	B	SIMS	100.00	SIMS	100.00	9.00
10.00	B	SIH CAYMAN	100.00	SIH CAYMAN	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: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet A-8-1 Date/Time Prepared: 8/18/2017 2:58 pm
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	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	220,541	9		1.00
2.00	5,566,965	9		2.00
3.00	4,950,114	0		3.00
4.00	6,971,436	0		4.00
4.01	3,818,224	0		4.01
4.02	15,504,978	0		4.02
4.03	-75,983	0		4.03
4.04	-9,898	0		4.04
4.05	-29,867	0		4.05
4.06	-6,568	0		4.06
4.07	-7,755	0		4.07
5.00	36,902,187			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	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		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: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet A-8-2

Date/Time Prepared:
8/18/2017 2:58 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	5,057,077	5,057,077	0	0	0	1.00
2.00	31.00	DR. B	48,425	0	48,425	179,000	372	2.00
3.00	35.00	DR. C	600	600	0	0	0	3.00
4.00	50.00	DR. D	164,821	163,281	1,540	246,400	14	4.00
5.00	54.02	DR. E	38,880	0	38,880	271,900	240	5.00
6.00	59.00	DR. F	64,997	0	64,997	179,000	244	6.00
7.00	60.00	DR. G	233,336	233,336	0	0	0	7.00
8.00	54.01	DR. H	805,368	640,671	164,697	271,900	938	8.00
9.00	69.00	DR. I	207,858	207,858	0	0	0	9.00
10.00	70.00	DR. J	6,200	6,200	0	0	0	10.00
11.00	91.00	DR. K	3,965,896	3,942,574	23,322	181,300	169	11.00
12.00	5.04	DR. L	583,664	576,014	7,650	179,000	51	12.00
13.00	52.00	DR. M	69,744	69,744	0	0	0	13.00
14.00	64.00	DR. N	35,126	0	35,126	197,500	182	14.00
200.00			11,281,992	10,897,355	384,637		2,210	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	0	0	0	0	0	1.00
2.00	31.00	DR. B	32,013	1,601	0	0	0	2.00
3.00	35.00	DR. C	0	0	0	0	0	3.00
4.00	50.00	DR. D	1,659	83	0	0	0	4.00
5.00	54.02	DR. E	31,373	1,569	0	0	0	5.00
6.00	59.00	DR. F	20,998	1,050	0	0	0	6.00
7.00	60.00	DR. G	0	0	0	0	0	7.00
8.00	54.01	DR. H	122,617	6,131	0	0	0	8.00
9.00	69.00	DR. I	0	0	0	0	0	9.00
10.00	70.00	DR. J	0	0	0	0	0	10.00
11.00	91.00	DR. K	14,731	737	0	0	0	11.00
12.00	5.04	DR. L	4,389	219	0	0	0	12.00
13.00	52.00	DR. M	0	0	0	0	0	13.00
14.00	64.00	DR. N	17,281	864	0	0	0	14.00
200.00			245,061	12,254	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	0	0	5,057,077		1.00
2.00	31.00	DR. B	0	32,013	16,412	16,412		2.00
3.00	35.00	DR. C	0	0	0	600		3.00
4.00	50.00	DR. D	0	1,659	0	163,281		4.00
5.00	54.02	DR. E	0	31,373	7,507	7,507		5.00
6.00	59.00	DR. F	0	20,998	43,999	43,999		6.00
7.00	60.00	DR. G	0	0	0	233,336		7.00
8.00	54.01	DR. H	0	122,617	42,080	682,751		8.00
9.00	69.00	DR. I	0	0	0	207,858		9.00
10.00	70.00	DR. J	0	0	0	6,200		10.00
11.00	91.00	DR. K	0	14,731	8,591	3,951,165		11.00
12.00	5.04	DR. L	0	4,389	3,261	579,275		12.00
13.00	52.00	DR. M	0	0	0	69,744		13.00
14.00	64.00	DR. N	0	17,281	17,845	17,845		14.00
200.00			0	245,061	139,695	11,037,050		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B
Part I
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,537,157	6,537,157			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	13,065,309		13,065,309		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	21,497,304	17,575	5,134	21,520,013	4.00
5.01 00550	DATA PROCESSING	6,971,436	29,751	0	0	7,001,187
5.02 00560	PURCHASING RECEIVING AND STORES	481,653	114,541	526	124,483	56,059
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	4,511,965	74,811	162	214,529	124,576
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	26,204,963	1,488,172	572,010	1,808,468	573,051
6.00 00600	MAINTENANCE & REPAIRS	2,500,603	721,683	2,165	208,199	124,576
8.00 00800	LAUNDRY & LINEN SERVICE	1,405,515	15,718	0	25,427	0
9.00 00900	HOUSEKEEPING	1,844,302	51,327	5,450	462,469	24,915
10.00 01000	DIETARY	656,370	75,816	33,300	117,476	87,203
11.00 01100	CAFETERIA	761,377	84,365	1,754	347,685	0
13.00 01300	NURSING ADMINISTRATION	952,806	61,562	569,525	293,305	105,890
14.00 01400	CENTRAL SERVICES & SUPPLY	416,730	32,680	3,309	104,660	24,915
16.00 01600	MEDICAL RECORDS & LIBRARY	531,802	0	6,582	184,351	155,720
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,095,789	0	0	365,796	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,398,005	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	18,204,650	1,126,716	401,752	4,738,720	1,476,231
31.00 03100	INTENSIVE CARE UNIT	4,563,486	216,805	207,987	1,220,871	323,898
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,043,343	31,641	86,895	310,233	49,831
43.00 04300	NURSERY	176,107	15,565	3,762	0	12,458
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	11,021,011	561,808	3,230,372	1,733,336	641,568
50.01 05001	SAME DAY SURGERY	0	0	0	0	0
51.00 05100	RECOVERY ROOM	766,991	47,036	61,756	248,427	149,492
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,820,686	165,358	134,633	1,135,318	161,949
53.00 05300	ANESTHESIOLOGY	1,174,583	7,204	51,456	212,967	87,203
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,733,511	147,647	1,322,233	890,272	218,008
54.01 03480	ONCOLOGY	1,963,663	171,829	1,531,221	281,529	224,237
54.02 03440	MAMMOGRAPHY	1,138,485	0	487,560	199,983	193,093
56.00 05600	RADIOISOTOPE	1,422,764	30,483	14,980	85,603	31,144
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	483,885	36,426	1,222,400	93,258	18,686
59.00 05900	CARDIAC CATHETERIZATION	6,979,225	223,872	1,753,695	1,227,470	398,644
60.00 06000	LABORATORY	7,503,848	154,885	489,470	759,148	242,924
64.00 06400	INTRAVENOUS THERAPY	830,075	77,144	38,441	184,166	112,119
65.00 06500	RESPIRATORY THERAPY	1,486,709	22,615	56,118	425,886	24,915
66.00 06600	PHYSICAL THERAPY	3,049,732	29,461	27,289	785,695	373,729
69.00 06900	ELECTROCARDIOLOGY	8,171,301	37,397	274,079	406,192	161,949
70.00 07000	ELECTROENCEPHALOGRAPHY	164,419	13,811	63,670	26,304	12,458
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,673,255	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	16,171,314	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	20,529,305	39,935	49,591	912,779	186,864
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,380,330	171,403	7,370	122,092	249,153
91.00 09100	EMERGENCY	4,620,826	0	347,116	1,262,916	373,729
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	220,906,590	6,097,042	13,063,763	21,520,013	7,001,187
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36,495	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	102,145	124,913	1,546	0	0
192.01 19201	FAMILY PRACTICE	0	0	0	0	0
192.02 19202	UNUSED SPACE	0	278,707	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	221,008,735	6,537,157	13,065,309	21,520,013	7,001,187

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B
Part I
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	777,262					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,907	4,927,950				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	168	0	30,646,832	30,646,832		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	3,557,226	572,685	4,129,911	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	301	0	1,446,961	232,949	15,869	8.00
9.00	00900	HOUSEKEEPING	191	0	2,388,654	384,554	51,820	9.00
10.00	01000	DIETARY	125	0	970,290	156,209	76,544	10.00
11.00	01100	CAFETERIA	369	0	1,195,550	192,474	85,175	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,983,088	319,261	62,153	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,436	0	584,730	94,137	32,994	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	878,455	141,424	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,461,585	235,303	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1,398,005	225,068	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	106,292	210,195	26,264,556	4,228,471	1,137,537	30.00
31.00	03100	INTENSIVE CARE UNIT	45,050	33,209	6,611,306	1,064,367	218,887	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	77	48,533	1,570,553	252,846	31,945	35.00
43.00	04300	NURSERY	11,284	9,570	228,746	36,826	15,715	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	319,544	728,589	18,236,228	2,935,887	567,204	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	996	59,834	1,334,532	214,849	47,488	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,109	99,971	5,540,024	891,900	166,946	52.00
53.00	05300	ANESTHESIOLOGY	27,990	101,125	1,662,528	267,654	7,273	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,864	583,167	6,931,702	1,115,949	149,065	54.00
54.01	03480	ONCOLOGY	115	229,760	4,402,354	708,744	173,479	54.01
54.02	03440	MAMMOGRAPHY	933	43,544	2,063,598	332,223	0	54.02
56.00	05600	RADIOISOTOPE	801	88,142	1,673,917	269,487	30,776	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,015	135,722	1,991,392	320,598	36,776	58.00
59.00	05900	CARDIAC CATHETERIZATION	100,140	354,320	11,037,366	1,776,928	226,022	59.00
60.00	06000	LABORATORY	13,310	431,822	9,595,407	1,544,784	156,372	60.00
64.00	06400	INTRAVENOUS THERAPY	14,294	31,879	1,288,118	207,377	77,885	64.00
65.00	06500	RESPIRATORY THERAPY	9,522	55,058	2,080,823	334,996	22,833	65.00
66.00	06600	PHYSICAL THERAPY	2,035	90,095	4,358,036	701,609	29,744	66.00
69.00	06900	ELECTROCARDIOLOGY	3,752	278,160	9,332,830	1,502,511	37,756	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,844	3,365	285,871	46,023	13,944	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	217,492	9,890,747	1,592,331	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	363,593	16,534,907	2,661,988	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,919	513,864	22,249,257	3,581,952	40,318	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	817	8,625	1,939,790	312,291	173,050	88.00
91.00	09100	EMERGENCY	36,062	208,316	6,848,965	1,102,629	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	777,262	4,927,950	220,464,929	30,559,284	3,685,570	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	36,495	5,875	36,845	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	228,604	36,803	126,112	192.00
192.01	19201	FAMILY PRACTICE	0	0	0	0	0	192.01
192.02	19202	UNUSED SPACE	0	0	278,707	44,870	281,384	192.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers			0		0	201.00
202.00		TOTAL (sum lines 118-201)	777,262	4,927,950	221,008,735	30,646,832	4,129,911	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B
Part I
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
8.00	00800	1,695,779					8.00
9.00	00900	0	2,825,028				9.00
10.00	01000	0	53,232	1,256,275			10.00
11.00	01100	0	59,234	0	1,532,433		11.00
13.00	01300	0	43,224	0	16,989	2,424,715	13.00
14.00	01400	0	22,945	0	18,688	0	14.00
16.00	01600	0	0	0	27,183	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	32,280	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,369,706	791,089	1,014,713	411,143	1,011,510	30.00
31.00	03100	220,054	152,222	163,021	88,344	216,848	31.00
35.00	02060	106,019	22,216	78,541	22,086	53,229	35.00
43.00	04300	0	10,929	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	394,456	0	147,807	361,628	50.00
50.01	05001	0	0	0	0	0	50.01
51.00	05100	0	33,025	0	15,290	36,133	51.00
52.00	05200	0	116,101	0	100,237	246,007	52.00
53.00	05300	0	5,058	0	13,591	0	53.00
54.00	05400	0	103,666	0	71,355	0	54.00
54.01	03480	0	120,644	0	23,785	0	54.01
54.02	03440	0	0	0	23,785	0	54.02
56.00	05600	0	21,403	0	5,097	0	56.00
58.00	05800	0	25,576	0	8,495	0	58.00
59.00	05900	0	157,184	0	88,344	218,915	59.00
60.00	06000	0	108,747	0	84,946	0	60.00
64.00	06400	0	54,164	0	18,688	0	64.00
65.00	06500	0	15,879	0	35,677	8,383	65.00
66.00	06600	0	20,685	0	61,161	0	66.00
69.00	06900	0	26,257	0	37,376	0	69.00
70.00	07000	0	9,697	0	1,699	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	28,039	0	49,269	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	120,345	0	18,688	0	88.00
91.00	09100	0	0	0	110,430	272,062	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		1,695,779	2,516,017	1,256,275	1,532,433	2,424,715	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	25,623	0	0	0	190.00
192.00	19200	0	87,703	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	195,685	0	0	0	192.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,695,779	2,825,028	1,256,275	1,532,433	2,424,715	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B
Part I
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description	INTERNS & RESIDENTS					
	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
	14.00	16.00	19.00	21.00	22.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01 00550 DATA PROCESSING					5.01	
5.02 00560 PURCHASING RECEIVING AND STORES					5.02	
5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE					5.03	
5.04 00590 OTHER ADMINISTRATIVE AND GENERAL					5.04	
6.00 00600 MAINTENANCE & REPAIRS					6.00	
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	753,494				14.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1,047,062			16.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0		19.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		1,696,888	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			22.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	147	44,660	0	252,683	30.00	
31.00 03100 INTENSIVE CARE UNIT	1,799	7,056	0	53,707	31.00	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	10,312	0	0	35.00	
43.00 04300 NURSERY	1	2,033	0	0	43.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	288,671	154,820	0	64,352	50.00	
50.01 05001 SAME DAY SURGERY	0	0	0	0	50.01	
51.00 05100 RECOVERY ROOM	3	12,713	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,696	21,241	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	5,538	21,486	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	33,060	123,906	0	27,662	54.00	
54.01 03480 ONCOLOGY	714	48,817	0	0	54.01	
54.02 03440 MAMMOGRAPHY	197	9,252	0	0	54.02	
56.00 05600 RADIOISOTOPE	486	18,728	0	0	56.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	767	28,837	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	407,221	75,283	0	0	59.00	
60.00 06000 LABORATORY	308	91,750	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	503	6,773	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	5,349	11,698	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	48	19,143	0	20,674	66.00	
69.00 06900 ELECTROCARDIOLOGY	4,734	59,101	0	16,080	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	298	715	0	3,882	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,111	46,211	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	77,253	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	109,181	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	566	1,832	0	314,252	88.00	
91.00 09100 EMERGENCY	277	44,261	0	74,769	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE					113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	753,494	1,047,062	0	828,061	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	
192.01 19201 FAMILY PRACTICE	0	0	0	868,827	192.01	
192.02 19202 UNUSED SPACE	0	0	0	0	192.02	
200.00	Cross Foot Adjustments			0	200.00	
201.00	Negative Cost Centers	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)	753,494	1,047,062	0	1,696,888	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B
Part I
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00580				5.03
5.04	00590				5.04
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
21.00	02100				21.00
22.00	02200				22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	36,772,713	-499,181	36,273,532	30.00
31.00	03100	8,850,004	-106,100	8,743,904	31.00
35.00	02060	2,147,747	0	2,147,747	35.00
43.00	04300	294,250	0	294,250	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	23,213,829	-127,128	23,086,701	50.00
50.01	05001	0	0	0	50.01
51.00	05100	1,694,033	0	1,694,033	51.00
52.00	05200	7,084,152	0	7,084,152	52.00
53.00	05300	1,983,128	0	1,983,128	53.00
54.00	05400	8,583,350	-54,647	8,528,703	54.00
54.01	03480	5,478,537	0	5,478,537	54.01
54.02	03440	2,429,055	0	2,429,055	54.02
56.00	05600	2,019,894	0	2,019,894	56.00
58.00	05800	2,412,441	0	2,412,441	58.00
59.00	05900	13,987,263	0	13,987,263	59.00
60.00	06000	11,582,314	0	11,582,314	60.00
64.00	06400	1,653,508	0	1,653,508	64.00
65.00	06500	2,515,638	0	2,515,638	65.00
66.00	06600	5,231,268	-40,842	5,190,426	66.00
69.00	06900	11,032,331	-31,766	11,000,565	69.00
70.00	07000	365,916	-7,669	358,247	70.00
71.00	07100	11,530,400	0	11,530,400	71.00
72.00	07200	19,274,148	0	19,274,148	72.00
73.00	07300	26,058,016	0	26,058,016	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	3,187,374	-620,812	2,566,562	88.00
91.00	09100	8,526,332	-147,708	8,378,624	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		217,907,641	-1,635,853	216,271,788	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	104,838	0	104,838	190.00
192.00	19200	479,222	0	479,222	192.00
192.01	19201	1,716,388	-1,716,388	0	192.01
192.02	19202	800,646	0	800,646	192.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		221,008,735	-3,352,241	217,656,494	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet Non-CMS W
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	9	MEALS SERVED	10.00
11.00	CAFETERIA	10	NUMBER OF FTES	11.00
13.00	NURSING ADMINISTRATION	11	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	12	COSTED REQS	14.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	13	DIRECT NURS. HRS.	19.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	14	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	14	ASSIGNED TIME	22.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B
Part II
Date/Time Prepared:
8/18/2017 2:58 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	17,575	5,134	22,709	22,709 4.00
5.01 00550	DATA PROCESSING	0	29,751	0	29,751	0 5.01
5.02 00560	PURCHASING RECEIVING AND STORES	0	114,541	526	115,067	131 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	74,811	162	74,973	226 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	0	1,488,172	572,010	2,060,182	1,907 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	721,683	2,165	723,848	220 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,718	0	15,718	27 8.00
9.00 00900	HOUSEKEEPING	0	51,327	5,450	56,777	488 9.00
10.00 01000	DIETARY	0	75,816	33,300	109,116	124 10.00
11.00 01100	CAFETERIA	0	84,365	1,754	86,119	367 11.00
13.00 01300	NURSING ADMINISTRATION	0	61,562	569,525	631,087	309 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	32,680	3,309	35,989	110 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	6,582	6,582	194 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	386 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,126,716	401,752	1,528,468	5,015 30.00
31.00 03100	INTENSIVE CARE UNIT	0	216,805	207,987	424,792	1,287 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	31,641	86,895	118,536	327 35.00
43.00 04300	NURSERY	0	15,565	3,762	19,327	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	561,808	3,230,372	3,792,180	1,828 50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	0 50.01
51.00 05100	RECOVERY ROOM	0	47,036	61,756	108,792	262 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	165,358	134,633	299,991	1,197 52.00
53.00 05300	ANESTHESIOLOGY	0	7,204	51,456	58,660	225 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	147,647	1,322,233	1,469,880	939 54.00
54.01 03480	ONCOLOGY	0	171,829	1,531,221	1,703,050	297 54.01
54.02 03440	MAMMOGRAPHY	0	0	487,560	487,560	211 54.02
56.00 05600	RADIOISOTOPE	0	30,483	14,980	45,463	90 56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	36,426	1,222,400	1,258,826	98 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	223,872	1,753,695	1,977,567	1,294 59.00
60.00 06000	LABORATORY	0	154,885	489,470	644,355	800 60.00
64.00 06400	INTRAVENOUS THERAPY	0	77,144	38,441	115,585	194 64.00
65.00 06500	RESPIRATORY THERAPY	0	22,615	56,118	78,733	449 65.00
66.00 06600	PHYSICAL THERAPY	0	29,461	27,289	56,750	828 66.00
69.00 06900	ELECTROCARDIOLOGY	0	37,397	274,079	311,476	428 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	13,811	63,670	77,481	28 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	39,935	49,591	89,526	962 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	171,403	7,370	178,773	129 88.00
91.00 09100	EMERGENCY	0	0	347,116	347,116	1,332 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	6,097,042	13,063,763	19,160,805	22,709 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36,495	0	36,495	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	124,913	1,546	126,459	0 192.00
192.01 19201	FAMILY PRACTICE	0	0	0	0	0 192.01
192.02 19202	UNUSED SPACE	0	278,707	0	278,707	0 192.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	6,537,157	13,065,309	19,602,466	22,709 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B
Part II
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	29,751					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	238	115,436				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	529	283	76,011			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,435	25	0	2,064,549		5.04
6.00	00600	MAINTENANCE & REPAIRS	529	0	0	38,578	763,175	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	45	0	15,692	2,933	8.00
9.00	00900	HOUSEKEEPING	106	28	0	25,905	9,576	9.00
10.00	01000	DIETARY	371	19	0	10,523	14,145	10.00
11.00	01100	CAFETERIA	0	55	0	12,966	15,740	11.00
13.00	01300	NURSING ADMINISTRATION	450	0	0	21,507	11,485	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106	362	0	6,341	6,097	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	662	0	0	9,527	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	15,851	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	15,161	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,275	15,786	3,236	284,910	210,206	30.00
31.00	03100	INTENSIVE CARE UNIT	1,376	6,690	511	71,700	40,449	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	212	11	747	17,033	5,903	35.00
43.00	04300	NURSERY	53	1,676	147	2,481	2,904	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,726	47,458	11,356	197,772	104,815	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	635	148	921	14,473	8,775	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	688	3,283	1,539	60,082	30,850	52.00
53.00	05300	ANESTHESIOLOGY	371	4,157	1,557	18,030	1,344	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	926	5,475	8,979	75,174	27,546	54.00
54.01	03480	ONCOLOGY	953	17	3,537	47,744	32,058	54.01
54.02	03440	MAMMOGRAPHY	821	139	670	22,380	0	54.02
56.00	05600	RADIOISOTOPE	132	119	1,357	18,154	5,687	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	79	151	2,090	21,597	6,796	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,694	14,872	5,455	119,700	41,767	59.00
60.00	06000	LABORATORY	1,032	1,977	6,649	104,062	28,896	60.00
64.00	06400	INTRAVENOUS THERAPY	476	2,123	491	13,970	14,393	64.00
65.00	06500	RESPIRATORY THERAPY	106	1,414	848	22,567	4,219	65.00
66.00	06600	PHYSICAL THERAPY	1,588	302	1,387	47,263	5,497	66.00
69.00	06900	ELECTROCARDIOLOGY	688	557	4,283	101,215	6,977	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	53	274	52	3,100	2,577	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,349	107,265	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,598	179,321	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	794	2,513	7,912	241,293	7,450	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,059	121	133	21,037	31,978	88.00
91.00	09100	EMERGENCY	1,588	5,356	3,207	74,277	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,751	115,436	76,011	2,058,651	681,063	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	396	6,809	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,479	23,305	192.00
192.01	19201	FAMILY PRACTICE	0	0	0	0	0	192.01
192.02	19202	UNUSED SPACE	0	0	0	3,023	51,998	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	29,751	115,436	76,011	2,064,549	763,175	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet B Part II Date/Time Prepared: 8/18/2017 2:58 pm
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,415				8.00
9.00	00900	HOUSEKEEPING	0	92,880			9.00
10.00	01000	DIETARY	0	1,750	136,048		10.00
11.00	01100	CAFETERIA	0	1,947	0	117,194	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,421	0	1,299	667,558
14.00	01400	CENTRAL SERVICES & SUPPLY	0	754	0	1,429	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,079	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	2,469	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,797	26,011	109,888	31,444	278,484
31.00	03100	INTENSIVE CARE UNIT	4,466	5,005	17,654	6,756	59,701
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,152	730	8,506	1,689	14,655
43.00	04300	NURSERY	0	359	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	12,969	0	11,304	99,561
50.01	05001	SAME DAY SURGERY	0	0	0	0	0
51.00	05100	RECOVERY ROOM	0	1,086	0	1,169	9,948
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,817	0	7,666	67,729
53.00	05300	ANESTHESIOLOGY	0	166	0	1,039	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,408	0	5,457	0
54.01	03480	ONCOLOGY	0	3,966	0	1,819	0
54.02	03440	MAMMOGRAPHY	0	0	0	1,819	0
56.00	05600	RADIOISOTOPE	0	704	0	390	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	841	0	650	0
59.00	05900	CARDIAC CATHETERIZATION	0	5,168	0	6,756	60,270
60.00	06000	LABORATORY	0	3,575	0	6,496	0
64.00	06400	INTRAVENOUS THERAPY	0	1,781	0	1,429	0
65.00	06500	RESPIRATORY THERAPY	0	522	0	2,728	2,308
66.00	06600	PHYSICAL THERAPY	0	680	0	4,677	0
69.00	06900	ELECTROCARDIOLOGY	0	863	0	2,858	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	319	0	130	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	922	0	3,768	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,957	0	1,429	0
91.00	09100	EMERGENCY	0	0	0	8,445	74,902
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,415	82,721	136,048	117,194	667,558
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	842	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,883	0	0	0
192.01	19201	FAMILY PRACTICE	0	0	0	0	0
192.02	19202	UNUSED SPACE	0	6,434	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	34,415	92,880	136,048	117,194	667,558

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B
Part II
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description	INTERNS & RESIDENTS					
	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
	14.00	16.00	19.00	21.00	22.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00 00600	MAINTENANCE & REPAIRS					6.00
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	51,188				14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	19,044			16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		16,237	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			22.00
						17,630
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10	809			30.00
31.00 03100	INTENSIVE CARE UNIT	122	128			31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	187			35.00
43.00 04300	NURSERY	0	37			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	19,611	2,879			50.00
50.01 05001	SAME DAY SURGERY	0	0			50.01
51.00 05100	RECOVERY ROOM	0	230			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	115	385			52.00
53.00 05300	ANESTHESIOLOGY	376	389			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,246	2,245			54.00
54.01 03480	ONCOLOGY	49	884			54.01
54.02 03440	MAMMOGRAPHY	13	168			54.02
56.00 05600	RADIOISOTOPE	33	339			56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	52	522			58.00
59.00 05900	CARDIAC CATHETERIZATION	27,666	1,364			59.00
60.00 06000	LABORATORY	21	1,662			60.00
64.00 06400	INTRAVENOUS THERAPY	34	123			64.00
65.00 06500	RESPIRATORY THERAPY	363	212			65.00
66.00 06600	PHYSICAL THERAPY	3	347			66.00
69.00 06900	ELECTROCARDIOLOGY	322	1,071			69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	20	13			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75	837			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,400			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,978			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	38	33			88.00
91.00 09100	EMERGENCY	19	802			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	51,188	19,044	0	0	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
192.01 19201	FAMILY PRACTICE	0	0			192.01
192.02 19202	UNUSED SPACE	0	0			192.02
200.00	Cross Foot Adjustments			0	16,237	17,630
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	51,188	19,044	0	16,237	17,630

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet B Part II Date/Time Prepared: 8/18/2017 2:58 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00580				5.03
5.04	00590				5.04
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
21.00	02100				21.00
22.00	02200				22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,528,339	0	2,528,339	30.00
31.00	03100	640,637	0	640,637	31.00
35.00	02060	170,688	0	170,688	35.00
43.00	04300	26,984	0	26,984	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	4,304,459	0	4,304,459	50.00
50.01	05001	0	0	0	50.01
51.00	05100	146,439	0	146,439	51.00
52.00	05200	477,342	0	477,342	52.00
53.00	05300	86,314	0	86,314	53.00
54.00	05400	1,602,275	0	1,602,275	54.00
54.01	03480	1,794,374	0	1,794,374	54.01
54.02	03440	513,781	0	513,781	54.02
56.00	05600	72,468	0	72,468	56.00
58.00	05800	1,291,702	0	1,291,702	58.00
59.00	05900	2,263,573	0	2,263,573	59.00
60.00	06000	799,525	0	799,525	60.00
64.00	06400	150,599	0	150,599	64.00
65.00	06500	114,469	0	114,469	65.00
66.00	06600	119,322	0	119,322	66.00
69.00	06900	430,738	0	430,738	69.00
70.00	07000	84,047	0	84,047	70.00
71.00	07100	111,526	0	111,526	71.00
72.00	07200	186,319	0	186,319	72.00
73.00	07300	357,118	0	357,118	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	238,687	0	238,687	88.00
91.00	09100	517,044	0	517,044	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		19,028,769	0	19,028,769	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	44,542	0	44,542	190.00
192.00	19200	155,126	0	155,126	192.00
192.01	19201	0	0	0	192.01
192.02	19202	340,162	0	340,162	192.02
200.00		33,867	0	33,867	200.00
201.00		0	0	0	201.00
202.00		19,602,466	0	19,602,466	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	383,869				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		7,181,710			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,032	2,822	64,465,915		4.00
5.01 00550	DATA PROCESSING	1,747	0	0	1,124	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	6,726	289	372,904	9	11,086,434
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	4,393	89	642,648	20	27,205
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	87,387	314,421	5,417,493	92	2,401
6.00 00600	MAINTENANCE & REPAIRS	42,378	1,190	623,686	20	0
8.00 00800	LAUNDRY & LINEN SERVICE	923	0	76,169	0	4,287
9.00 00900	HOUSEKEEPING	3,014	2,996	1,385,384	4	2,721
10.00 01000	DIETARY	4,452	18,304	351,913	14	1,779
11.00 01100	CAFETERIA	4,954	964	1,041,533	0	5,264
13.00 01300	NURSING ADMINISTRATION	3,615	313,055	878,633	17	0
14.00 01400	CENTRAL SERVICES & SUPPLY	1,919	1,819	313,522	4	34,739
16.00 01600	MEDICAL RECORDS & LIBRARY	0	3,618	552,247	25	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,095,789	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	66,162	220,834	14,195,436	237	1,516,101
31.00 03100	INTENSIVE CARE UNIT	12,731	114,326	3,657,272	52	642,566
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,858	47,764	929,342	8	1,097
43.00 04300	NURSERY	914	2,068	0	2	160,946
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	32,990	1,775,665	5,192,427	103	4,557,814
50.01 05001	SAME DAY SURGERY	0	0	0	0	0
51.00 05100	RECOVERY ROOM	2,762	33,946	744,195	24	14,212
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,710	74,005	3,400,989	26	315,349
53.00 05300	ANESTHESIOLOGY	423	28,284	637,969	14	399,236
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,670	726,802	2,666,922	35	525,803
54.01 03480	ONCOLOGY	10,090	841,678	843,357	36	1,634
54.02 03440	MAMMOGRAPHY	0	268,001	599,074	31	13,309
56.00 05600	RADIOISOTOPE	1,790	8,234	256,435	5	11,431
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	2,139	671,926	279,365	3	14,471
59.00 05900	CARDIAC CATHETERIZATION	13,146	963,967	3,677,041	64	1,428,348
60.00 06000	LABORATORY	9,095	269,051	2,274,125	39	189,850
64.00 06400	INTRAVENOUS THERAPY	4,530	21,130	551,693	18	203,878
65.00 06500	RESPIRATORY THERAPY	1,328	30,847	1,275,796	4	135,818
66.00 06600	PHYSICAL THERAPY	1,730	15,000	2,353,650	60	29,020
69.00 06900	ELECTROCARDIOLOGY	2,196	150,655	1,216,798	26	53,511
70.00 07000	ELECTROENCEPHALOGRAPHY	811	34,998	78,796	2	26,301
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	2,345	27,259	2,734,345	30	241,325
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	10,065	4,051	365,743	40	11,648
91.00 09100	EMERGENCY	0	190,802	3,783,224	60	514,370
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	358,025	7,180,860	64,465,915	1,124	11,086,434
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,143	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	7,335	850	0	0	0
192.01 19201	FAMILY PRACTICE	0	0	0	0	0
192.02 19202	UNUSED SPACE	16,366	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	6,537,157	13,065,309	21,520,013	7,001,187	777,262
203.00	Unit cost multiplier (Wkst. B, Part I)	17.029656	1.819248	0.333820	6,228.814057	0.070109
204.00	Cost to be allocated (per Wkst. B, Part II)			22,709	29,751	115,436
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000352	26.468861	0.010412

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B-1

Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
		5.03	5A.04	5.04	6.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580	948,379,709					5.03
5.04	00590	0	-30,646,832	190,361,903			5.04
6.00	00600	0	0	3,557,226	240,206		6.00
8.00	00800	0	0	1,446,961	923	35,541	8.00
9.00	00900	0	0	2,388,654	3,014	0	9.00
10.00	01000	0	0	970,290	4,452	0	10.00
11.00	01100	0	0	1,195,550	4,954	0	11.00
13.00	01300	0	0	1,983,088	3,615	0	13.00
14.00	01400	0	0	584,730	1,919	0	14.00
16.00	01600	0	0	878,455	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	1,461,585	0	0	21.00
22.00	02200	0	0	1,398,005	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	40,453,261	0	26,264,556	66,162	28,707	30.00
31.00	03100	6,391,300	0	6,611,306	12,731	4,612	31.00
35.00	02060	9,340,388	0	1,570,553	1,858	2,222	35.00
43.00	04300	1,841,853	0	228,746	914	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	140,188,863	0	18,236,228	32,990	0	50.00
50.01	05001	0	0	0	0	0	50.01
51.00	05100	11,515,327	0	1,334,532	2,762	0	51.00
52.00	05200	19,239,971	0	5,540,024	9,710	0	52.00
53.00	05300	19,462,067	0	1,662,528	423	0	53.00
54.00	05400	112,233,913	0	6,931,702	8,670	0	54.00
54.01	03480	44,218,679	0	4,402,354	10,090	0	54.01
54.02	03440	8,380,368	0	2,063,598	0	0	54.02
56.00	05600	16,963,490	0	1,673,917	1,790	0	56.00
58.00	05800	26,120,418	0	1,991,392	2,139	0	58.00
59.00	05900	68,190,837	0	11,037,366	13,146	0	59.00
60.00	06000	83,106,675	0	9,595,407	9,095	0	60.00
64.00	06400	6,135,289	0	1,288,118	4,530	0	64.00
65.00	06500	10,596,142	0	2,080,823	1,328	0	65.00
66.00	06600	17,339,302	0	4,358,036	1,730	0	66.00
69.00	06900	53,533,489	0	9,332,830	2,196	0	69.00
70.00	07000	647,576	0	285,871	811	0	70.00
71.00	07100	41,857,497	0	9,890,747	0	0	71.00
72.00	07200	69,975,472	0	16,534,907	0	0	72.00
73.00	07300	98,896,152	0	22,249,257	2,345	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,659,841	0	1,939,790	10,065	0	88.00
91.00	09100	40,091,539	0	6,848,965	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		948,379,709	-30,646,832	189,818,097	214,362	35,541	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	36,495	2,143	0	190.00
192.00	19200	0	0	228,604	7,335	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	278,707	16,366	0	192.02
200.00							200.00
201.00							201.00
202.00		4,927,950		30,646,832	4,129,911	1,695,779	202.00
203.00		0.005196		0.160992	17.193205	47.713317	203.00
204.00		76,011		2,064,549	763,175	34,415	204.00
205.00		0.000080		0.010845	3.177169	0.968318	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B-1

Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQS)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
8.00	00800						8.00
9.00	00900	236,269					9.00
10.00	01000	4,452	106,623				10.00
11.00	01100	4,954	0	902			11.00
13.00	01300	3,615	0	10	1,207,012		13.00
14.00	01400	1,919	0	11	0	16,386,153	14.00
16.00	01600	0	0	16	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	19	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	66,162	86,121	242	503,525	3,199	30.00
31.00	03100	12,731	13,836	52	107,946	39,115	31.00
35.00	02060	1,858	6,666	13	26,497	2	35.00
43.00	04300	914	0	0	0	14	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	32,990	0	87	180,017	6,277,642	50.00
50.01	05001	0	0	0	0	0	50.01
51.00	05100	2,762	0	9	17,987	75	51.00
52.00	05200	9,710	0	59	122,461	36,886	52.00
53.00	05300	423	0	8	0	120,429	53.00
54.00	05400	8,670	0	42	0	718,946	54.00
54.01	03480	10,090	0	14	0	15,527	54.01
54.02	03440	0	0	14	0	4,287	54.02
56.00	05600	1,790	0	3	0	10,564	56.00
58.00	05800	2,139	0	5	0	16,685	58.00
59.00	05900	13,146	0	52	108,975	8,855,858	59.00
60.00	06000	9,095	0	50	0	6,699	60.00
64.00	06400	4,530	0	11	0	10,937	64.00
65.00	06500	1,328	0	21	4,173	116,323	65.00
66.00	06600	1,730	0	36	0	1,035	66.00
69.00	06900	2,196	0	22	0	102,941	69.00
70.00	07000	811	0	1	0	6,485	70.00
71.00	07100	0	0	0	0	24,166	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,345	0	29	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	10,065	0	11	0	12,314	88.00
91.00	09100	0	0	65	135,431	6,024	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		210,425	106,623	902	1,207,012	16,386,153	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,143	0	0	0	0	190.00
192.00	19200	7,335	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	16,366	0	0	0	0	192.02
200.00							200.00
201.00							201.00
202.00		2,825,028	1,256,275	1,532,433	2,424,715	753,494	202.00
203.00		11.956829	11.782402	1,698.927938	2.008857	0.045984	203.00
204.00		92,880	136,048	117,194	667,558	51,188	204.00
205.00		0.393111	1.275972	129.926829	0.553067	0.003124	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet B-1

Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (DIRECT NURS. HRS.)	INTERNS & RESIDENTS			
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
			16.00	19.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00 00600	MAINTENANCE & REPAIRS					6.00
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
16.00 01600	MEDICAL RECORDS & LIBRARY	948,379,709				16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	100			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0		52,448		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0			52,448	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	40,453,261	0	7,810	7,810	30.00
31.00 03100	INTENSIVE CARE UNIT	6,391,300	0	1,660	1,660	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	9,340,388	0	0	0	35.00
43.00 04300	NURSERY	1,841,853	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	140,188,863	0	1,989	1,989	50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	50.01
51.00 05100	RECOVERY ROOM	11,515,327	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	19,239,971	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	19,462,067	100	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	112,233,913	0	855	855	54.00
54.01 03480	ONCOLOGY	44,218,679	0	0	0	54.01
54.02 03440	MAMMOGRAPHY	8,380,368	0	0	0	54.02
56.00 05600	RADIOISOTOPE	16,963,490	0	0	0	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	26,120,418	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	68,190,837	0	0	0	59.00
60.00 06000	LABORATORY	83,106,675	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	6,135,289	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	10,596,142	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	17,339,302	0	639	639	66.00
69.00 06900	ELECTROCARDIOLOGY	53,533,489	0	497	497	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	647,576	0	120	120	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,857,497	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	69,975,472	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	98,896,152	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,659,841	0	9,713	9,713	88.00
91.00 09100	EMERGENCY	40,091,539	0	2,311	2,311	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	948,379,709	100	25,594	25,594	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
192.01 19201	FAMILY PRACTICE	0	0	26,854	26,854	192.01
192.02 19202	UNUSED SPACE	0	0	0	0	192.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,047,062	0	1,696,888	1,655,353	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.001104	0.000000	32.353722	31.561795	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	19,044	0	16,237	17,630	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000020	0.000000	0.309583	0.336142	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet C
Part I
Date/Time Prepared:
8/18/2017 2:58 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		36,273,532	0	36,273,532	30.00
31.00	03100 INTENSIVE CARE UNIT		8,743,904	16,412	8,760,316	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		2,147,747	0	2,147,747	35.00
43.00	04300 NURSERY		294,250	0	294,250	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		23,086,701	0	23,086,701	50.00
50.01	05001 SAME DAY SURGERY		0	0	0	50.01
51.00	05100 RECOVERY ROOM		1,694,033	0	1,694,033	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		7,084,152	0	7,084,152	52.00
53.00	05300 ANESTHESIOLOGY		1,983,128	0	1,983,128	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		8,528,703	0	8,528,703	54.00
54.01	03480 ONCOLOGY		5,478,537	42,080	5,520,617	54.01
54.02	03440 MAMMOGRAPHY		2,429,055	7,507	2,436,562	54.02
56.00	05600 RADIOISOTOPE		2,019,894	0	2,019,894	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		2,412,441	0	2,412,441	58.00
59.00	05900 CARDIAC CATHETERIZATION		13,987,263	43,999	14,031,262	59.00
60.00	06000 LABORATORY		11,582,314	0	11,582,314	60.00
64.00	06400 INTRAVENOUS THERAPY		1,653,508	17,845	1,671,353	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,515,638	0	2,515,638	65.00
66.00	06600 PHYSICAL THERAPY	0	5,190,426	0	5,190,426	66.00
69.00	06900 ELECTROCARDIOLOGY		11,000,565	0	11,000,565	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		358,247	0	358,247	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		11,530,400	0	11,530,400	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		19,274,148	0	19,274,148	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		26,058,016	0	26,058,016	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		2,566,562	0	2,566,562	88.00
91.00	09100 EMERGENCY		8,378,624	8,591	8,387,215	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		4,165,327	0	4,165,327	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		220,437,115	0	220,437,115	200.00
201.00	Less Observation Beds		4,165,327		4,165,327	201.00
202.00	Total (see instructions)		216,271,788	0	216,271,788	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet C Part I Date/Time Prepared: 8/18/2017 2:58 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	33,029,092		33,029,092	30.00
31.00	03100	INTENSIVE CARE UNIT	6,391,300		6,391,300	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	9,328,616		9,328,616	35.00
43.00	04300	NURSERY	1,841,853		1,841,853	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	79,889,313	58,928,735	138,818,048	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	50.01
51.00	05100	RECOVERY ROOM	5,525,712	5,606,187	11,131,899	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,548,343	4,624,083	19,172,426	52.00
53.00	05300	ANESTHESIOLOGY	11,182,985	8,090,767	19,273,752	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,909,924	82,192,454	111,102,378	54.00
54.01	03480	ONCOLOGY	141,169	43,999,368	44,140,537	54.01
54.02	03440	MAMMOGRAPHY	3,269	8,185,129	8,188,398	54.02
56.00	05600	RADIOISOTOPE	4,059,260	12,679,125	16,738,385	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,030,364	21,282,361	25,312,725	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,302,783	42,574,604	67,877,387	59.00
60.00	06000	LABORATORY	35,581,096	45,939,394	81,520,490	60.00
64.00	06400	INTRAVENOUS THERAPY	23,892	6,096,871	6,120,763	64.00
65.00	06500	RESPIRATORY THERAPY	9,194,566	1,393,333	10,587,899	65.00
66.00	06600	PHYSICAL THERAPY	4,564,689	12,419,255	16,983,944	66.00
69.00	06900	ELECTROCARDIOLOGY	12,239,130	38,712,032	50,951,162	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	307,736	338,909	646,645	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,091,130	16,405,976	38,497,106	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,855,520	31,810,371	69,665,891	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,680,894	63,596,911	101,277,805	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,659,841	1,659,841	88.00
91.00	09100	EMERGENCY	8,344,530	31,459,601	39,804,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,185,773	6,124,084	7,309,857	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	393,252,939	544,119,391	937,372,330	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	393,252,939	544,119,391	937,372,330	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet C Part I Date/Time Prepared: 8/18/2017 2:58 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital PPS
		INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.166309		50.00
50.01	05001	SAME DAY SURGERY	0.000000		50.01
51.00	05100	RECOVERY ROOM	0.152178		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.369497		52.00
53.00	05300	ANESTHESIOLOGY	0.102893		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076764		54.00
54.01	03480	ONCOLOGY	0.125069		54.01
54.02	03440	MAMMOGRAPHY	0.297563		54.02
56.00	05600	RADIOISOTOPE	0.120674		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.095305		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.206715		59.00
60.00	06000	LABORATORY	0.142079		60.00
64.00	06400	INTRAVENOUS THERAPY	0.273063		64.00
65.00	06500	RESPIRATORY THERAPY	0.237596		65.00
66.00	06600	PHYSICAL THERAPY	0.305608		66.00
69.00	06900	ELECTROCARDIOLOGY	0.215904		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.554009		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.299513		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.276665		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257292		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.210712		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569823		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet C
Part I
Date/Time Prepared:
8/18/2017 2:58 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	36,273,532	36,273,532	0	36,273,532	30.00
31.00	03100 INTENSIVE CARE UNIT	8,743,904	8,743,904	16,412	8,760,316	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	2,147,747	2,147,747	0	2,147,747	35.00
43.00	04300 NURSERY	294,250	294,250	0	294,250	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	23,086,701	23,086,701	0	23,086,701	50.00
50.01	05001 SAME DAY SURGERY	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	1,694,033	1,694,033	0	1,694,033	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,084,152	7,084,152	0	7,084,152	52.00
53.00	05300 ANESTHESIOLOGY	1,983,128	1,983,128	0	1,983,128	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,528,703	8,528,703	0	8,528,703	54.00
54.01	03480 ONCOLOGY	5,478,537	5,478,537	42,080	5,520,617	54.01
54.02	03440 MAMMOGRAPHY	2,429,055	2,429,055	7,507	2,436,562	54.02
56.00	05600 RADIOISOTOPE	2,019,894	2,019,894	0	2,019,894	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,412,441	2,412,441	0	2,412,441	58.00
59.00	05900 CARDIAC CATHETERIZATION	13,987,263	13,987,263	43,999	14,031,262	59.00
60.00	06000 LABORATORY	11,582,314	11,582,314	0	11,582,314	60.00
64.00	06400 INTRAVENOUS THERAPY	1,653,508	1,653,508	17,845	1,671,353	64.00
65.00	06500 RESPIRATORY THERAPY	2,515,638	2,515,638	0	2,515,638	65.00
66.00	06600 PHYSICAL THERAPY	5,190,426	5,190,426	0	5,190,426	66.00
69.00	06900 ELECTROCARDIOLOGY	11,000,565	11,000,565	0	11,000,565	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	358,247	358,247	0	358,247	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,530,400	11,530,400	0	11,530,400	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19,274,148	19,274,148	0	19,274,148	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,058,016	26,058,016	0	26,058,016	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	2,566,562	2,566,562	0	2,566,562	88.00
91.00	09100 EMERGENCY	8,378,624	8,378,624	8,591	8,387,215	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,165,327	4,165,327	0	4,165,327	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	220,437,115	220,437,115	136,434	220,573,549	200.00
201.00	Less Observation Beds	4,165,327	4,165,327		4,165,327	201.00
202.00	Total (see instructions)	216,271,788	216,271,788	136,434	216,408,222	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet C
Part I
Date/Time Prepared:
8/18/2017 2:58 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	33,029,092		33,029,092			30.00
31.00	03100	INTENSIVE CARE UNIT	6,391,300		6,391,300			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	9,328,616		9,328,616			35.00
43.00	04300	NURSERY	1,841,853		1,841,853			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	79,889,313	58,928,735	138,818,048	0.166309	0.000000	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0.000000	0.000000	50.01
51.00	05100	RECOVERY ROOM	5,525,712	5,606,187	11,131,899	0.152178	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,548,343	4,624,083	19,172,426	0.369497	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,182,985	8,090,767	19,273,752	0.102893	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,909,924	82,192,454	111,102,378	0.076764	0.000000	54.00
54.01	03480	ONCOLOGY	141,169	43,999,368	44,140,537	0.124116	0.000000	54.01
54.02	03440	MAMMOGRAPHY	3,269	8,185,129	8,188,398	0.296646	0.000000	54.02
56.00	05600	RADIOISOTOPE	4,059,260	12,679,125	16,738,385	0.120674	0.000000	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,030,364	21,282,361	25,312,725	0.095305	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,302,783	42,574,604	67,877,387	0.206067	0.000000	59.00
60.00	06000	LABORATORY	35,581,096	45,939,394	81,520,490	0.142079	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	23,892	6,096,871	6,120,763	0.270147	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	9,194,566	1,393,333	10,587,899	0.237596	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,564,689	12,419,255	16,983,944	0.305608	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,239,130	38,712,032	50,951,162	0.215904	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	307,736	338,909	646,645	0.554009	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,091,130	16,405,976	38,497,106	0.299513	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,855,520	31,810,371	69,665,891	0.276665	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,680,894	63,596,911	101,277,805	0.257292	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,659,841	1,659,841	1.546270	0.000000	88.00
91.00	09100	EMERGENCY	8,344,530	31,459,601	39,804,131	0.210496	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,185,773	6,124,084	7,309,857	0.569823	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	393,252,939	544,119,391	937,372,330			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	393,252,939	544,119,391	937,372,330			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet C Part I Date/Time Prepared: 8/18/2017 2:58 pm
Cost Center Description			PPS Inpatient Ratio 11.00	Title XIX	Hospital Cost
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
50.01	05001	SAME DAY SURGERY	0.000000		50.01
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03480	ONCOLOGY	0.000000		54.01
54.02	03440	MAMMOGRAPHY	0.000000		54.02
56.00	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part I Date/Time Prepared: 8/18/2017 2:58 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,528,339	0	2,528,339	30,410	83.14	30.00
31.00	INTENSIVE CARE UNIT	640,637		640,637	4,612	138.91	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	170,688		170,688	2,222	76.82	35.00
43.00	NURSERY	26,984		26,984	2,795	9.65	43.00
200.00	Total (lines 30-199)	3,366,648		3,366,648	40,039		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	12,490	1,038,419	30.00
31.00	INTENSIVE CARE UNIT	2,108	292,822	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0	35.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	14,598	1,331,241	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet D
Part II
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,304,459	138,818,048	0.031008	43,256,421	1,341,295	50.00
50.01	05001	SAME DAY SURGERY	0	0	0.000000	0	0	50.01
51.00	05100	RECOVERY ROOM	146,439	11,131,899	0.013155	2,387,382	31,406	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	477,342	19,172,426	0.024897	28,105	700	52.00
53.00	05300	ANESTHESIOLOGY	86,314	19,273,752	0.004478	4,488,192	20,098	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,602,275	111,102,378	0.014422	14,217,840	205,050	54.00
54.01	03480	ONCOLOGY	1,794,374	44,140,537	0.040651	139,201	5,659	54.01
54.02	03440	MAMMOGRAPHY	513,781	8,188,398	0.062745	1,083	68	54.02
56.00	05600	RADIOISOTOPE	72,468	16,738,385	0.004329	2,307,225	9,988	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,291,702	25,312,725	0.051030	1,973,998	100,733	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,263,573	67,877,387	0.033348	5,131,665	171,131	59.00
60.00	06000	LABORATORY	799,525	81,520,490	0.009808	17,807,882	174,660	60.00
64.00	06400	INTRAVENOUS THERAPY	150,599	6,120,763	0.024605	7,045	173	64.00
65.00	06500	RESPIRATORY THERAPY	114,469	10,587,899	0.010811	4,839,026	52,315	65.00
66.00	06600	PHYSICAL THERAPY	119,322	16,983,944	0.007026	2,482,990	17,445	66.00
69.00	06900	ELECTROCARDIOLOGY	430,738	50,951,162	0.008454	6,074,074	51,350	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	84,047	646,645	0.129974	108,929	14,158	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	111,526	38,497,106	0.002897	9,513,452	27,560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,319	69,665,891	0.002674	15,919,879	42,570	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	357,118	101,277,805	0.003526	18,135,736	63,947	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	238,687	1,659,841	0.143801	0	0	88.00
91.00	09100	EMERGENCY	517,044	39,804,131	0.012990	3,686,168	47,883	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	290,332	7,309,857	0.039718	464,298	18,441	92.00
200.00		Total (lines 50-199)	15,952,453	886,781,469		152,970,591	2,396,630	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part III Date/Time Prepared: 8/18/2017 2:58 pm
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Cost Center Description	Title XVIII				Hospital	PPS
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	35.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	200.00

Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School
	6.00	7.00	8.00	9.00	11.00

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,410	0.00	12,490	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,612	0.00	2,108	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,222	0.00	0	0	35.00
43.00	04300	NURSERY	2,795	0.00	0	0	43.00
200.00		Total (lines 30-199)	40,039		14,598	0	200.00

Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost
	12.00	13.00

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0			35.00
43.00	04300	NURSERY	0	0			43.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet D
Part IV
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description		Title XVIII			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet D
Part IV
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	138,818,048	0.000000	0.000000	43,256,421	50.00
50.01	05001	SAME DAY SURGERY	0	0	0.000000	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0	11,131,899	0.000000	0.000000	2,387,382	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,172,426	0.000000	0.000000	28,105	52.00
53.00	05300	ANESTHESIOLOGY	0	19,273,752	0.000000	0.000000	4,488,192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	111,102,378	0.000000	0.000000	14,217,840	54.00
54.01	03480	ONCOLOGY	0	44,140,537	0.000000	0.000000	139,201	54.01
54.02	03440	MAMMOGRAPHY	0	8,188,398	0.000000	0.000000	1,083	54.02
56.00	05600	RADIOISOTOPE	0	16,738,385	0.000000	0.000000	2,307,225	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	25,312,725	0.000000	0.000000	1,973,998	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	67,877,387	0.000000	0.000000	5,131,665	59.00
60.00	06000	LABORATORY	0	81,520,490	0.000000	0.000000	17,807,882	60.00
64.00	06400	INTRAVENOUS THERAPY	0	6,120,763	0.000000	0.000000	7,045	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,587,899	0.000000	0.000000	4,839,026	65.00
66.00	06600	PHYSICAL THERAPY	0	16,983,944	0.000000	0.000000	2,482,990	66.00
69.00	06900	ELECTROCARDIOLOGY	0	50,951,162	0.000000	0.000000	6,074,074	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	646,645	0.000000	0.000000	108,929	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,497,106	0.000000	0.000000	9,513,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	69,665,891	0.000000	0.000000	15,919,879	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	101,277,805	0.000000	0.000000	18,135,736	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,659,841	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	39,804,131	0.000000	0.000000	3,686,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,309,857	0.000000	0.000000	464,298	92.00
200.00		Total (lines 50-199)	0	886,781,469			152,970,591	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part IV Date/Time Prepared: 8/18/2017 2:58 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	30,321,077	0	0	0 50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0 50.01
51.00	05100	RECOVERY ROOM	0	3,625,489	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	2,190,490	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,463,566	0	0	0 54.00
54.01	03480	ONCOLOGY	0	18,207,864	0	0	0 54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0 54.02
56.00	05600	RADIOISOTOPE	0	11,665,703	0	0	0 56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,207,393	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,996,843	0	0	0 59.00
60.00	06000	LABORATORY	0	9,714,166	0	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,823,377	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	421,552	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	79,182	0	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,213,684	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	75,469	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,584,917	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,410,492	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,063,166	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
91.00	09100	EMERGENCY	0	6,154,064	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,036,834	0	0	0 92.00
200.00		Total (lines 50-199)	0	171,255,328	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part IV Date/Time Prepared: 8/18/2017 2:58 pm
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Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
50.01	05001 SAME DAY SURGERY	0	0			50.01
51.00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
54.01	03480 ONCOLOGY	0	0			54.01
54.02	03440 MAMMOGRAPHY	0	0			54.02
56.00	05600 RADIOISOTOPE	0	0			56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
64.00	06400 INTRAVENOUS THERAPY	0	0			64.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part V Date/Time Prepared: 8/18/2017 2:58 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.166309	30,321,077	0	0	5,042,668	50.00
50.01	05001	SAME DAY SURGERY	0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.152178	3,625,489	0	0	551,720	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.369497	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.102893	2,190,490	0	0	225,386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076764	22,463,566	0	0	1,724,393	54.00
54.01	03480	ONCOLOGY	0.124116	18,207,864	0	0	2,259,887	54.01
54.02	03440	MAMMOGRAPHY	0.296646	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.120674	11,665,703	0	0	1,407,747	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.095305	5,207,393	0	0	496,291	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.206067	10,996,843	0	0	2,266,086	59.00
60.00	06000	LABORATORY	0.142079	9,714,166	16,342	0	1,380,179	60.00
64.00	06400	INTRAVENOUS THERAPY	0.270147	2,823,377	0	0	762,727	64.00
65.00	06500	RESPIRATORY THERAPY	0.237596	421,552	0	0	100,159	65.00
66.00	06600	PHYSICAL THERAPY	0.305608	79,182	0	0	24,199	66.00
69.00	06900	ELECTROCARDIOLOGY	0.215904	8,213,684	0	0	1,773,367	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.554009	75,469	0	0	41,811	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.299513	6,584,917	0	0	1,972,268	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.276665	17,410,492	0	0	4,816,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257292	13,063,166	0	47,120	3,361,048	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.210496	6,154,064	0	0	1,295,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569823	2,036,834	0	0	1,160,635	92.00
200.00		Subtotal (see instructions)		171,255,328	16,342	47,120	30,662,851	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)		171,255,328	16,342	47,120	30,662,851	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part V Date/Time Prepared: 8/18/2017 2:58 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
50.01	05001	SAME DAY SURGERY	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03480	ONCOLOGY	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	2,322	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,124	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	2,322	12,124	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	2,322	12,124	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet D-1 Date/Time Prepared: 8/18/2017 2:58 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)		30,410	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		30,410	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)		26,918	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)		12,490	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)		36,273,532	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)		36,273,532	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)		36,273,532	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)		1,192.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,898,322	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)		14,898,322	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet D-1 Date/Time Prepared: 8/18/2017 2:58 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	8,760,316	4,612	1,899.46	2,108	4,004,062	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	NEONATAL INTENSIVE CARE UNIT	2,147,747	2,222	966.58	0	0	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					29,439,638	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					48,342,022	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,331,241	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,396,630	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,727,871	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					44,614,151	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)					3,492	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,192.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,165,327	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0164		Period: From 04/01/2016 To 03/31/2017		Worksheet D-1 Date/Time Prepared: 8/18/2017 2:58 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,528,339	36,273,532	0.069702	4,165,327	290,332	90.00
91.00	Nursing School cost	0	36,273,532	0.000000	4,165,327	0	91.00
92.00	Allied health cost	0	36,273,532	0.000000	4,165,327	0	92.00
93.00	All other Medical Education	0	36,273,532	0.000000	4,165,327	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet D-3 Date/Time Prepared: 8/18/2017 2:58 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		13,392,534	30.00
31.00	03100	INTENSIVE CARE UNIT		2,883,744	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.166309	43,256,421	50.00
50.01	05001	SAME DAY SURGERY	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0.152178	2,387,382	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.369497	28,105	52.00
53.00	05300	ANESTHESIOLOGY	0.102893	4,488,192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076764	14,217,840	54.00
54.01	03480	ONCOLOGY	0.125069	139,201	54.01
54.02	03440	MAMMOGRAPHY	0.297563	1,083	54.02
56.00	05600	RADIOISOTOPE	0.120674	2,307,225	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.095305	1,973,998	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.206715	5,131,665	59.00
60.00	06000	LABORATORY	0.142079	17,807,882	60.00
64.00	06400	INTRAVENOUS THERAPY	0.273063	7,045	64.00
65.00	06500	RESPIRATORY THERAPY	0.237596	4,839,026	65.00
66.00	06600	PHYSICAL THERAPY	0.305608	2,482,990	66.00
69.00	06900	ELECTROCARDIOLOGY	0.215904	6,074,074	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.554009	108,929	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.299513	9,513,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.276665	15,919,879	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257292	18,135,736	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.210712	3,686,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569823	464,298	92.00
200.00		Total (sum of lines 50-94 and 96-98)		152,970,591	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)		152,970,591	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part A Date/Time Prepared: 8/18/2017 2:58 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		15,899,214	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		17,336,308	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		1,208,254	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		5,325,974	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		156.78	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		5.17	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		5.17	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		16.64	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		5.17	12.00
13.00	Total allowable FTE count for the prior year.		5.17	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		5.17	14.00
15.00	Sum of lines 12 through 14 divided by 3.		5.17	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		5.17	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.032976	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.032896	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.032896	21.00
22.00	IME payment adjustment (see instructions)		592,024	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		94,872	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		7.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		11.47	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		7.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.044649	26.00
27.00	IME payments adjustment factor. (see instructions)		0.011780	27.00
28.00	IME add-on adjustment amount (see instructions)		391,514	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		62,740	28.01
29.00	Total IME payment (sum of lines 22 and 28)		983,538	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		157,612	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.52	30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.74	31.00
32.00	Sum of lines 30 and 31		33.26	32.00
33.00	Allowable disproportionate share percentage (see instructions)		16.65	33.00
34.00	Disproportionate share adjustment (see instructions)		1,383,429	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part A Date/Time Prepared: 8/18/2017 2:58 pm	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,881,976	1,829,115	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		940,988	912,052	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,853,040		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		38,663,783		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			38,821,395	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			2,992,027	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			366,267	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			13,460	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			42,193,149	59.00
60.00	Primary payer payments			7,919	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			42,185,230	61.00
62.00	Deductibles billed to program beneficiaries			3,408,412	62.00
63.00	Coinurance billed to program beneficiaries			71,869	63.00
64.00	Allowable bad debts (see instructions)			795,767	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			517,249	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			505,080	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			39,222,198	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	RURAL DEMONSTRATION PROJECT			0	70.50
70.88	SCH or MDH volume decrease adjustment			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			70,357	70.93
70.94	HRR adjustment amount (see instructions)			-216,522	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part A Date/Time Prepared: 8/18/2017 2:58 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			39,076,033	71.00
71.01	Sequestration adjustment (see instructions)			781,521	71.01
72.00	Interim payments			38,078,495	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			216,017	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0164		Period: From 04/01/2016 To 03/31/2017		Worksheet DSH	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	5.52	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	27.74	0.00			27.74	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	33.26	0.00			27.74	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	156.78	0.00			156.78	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	16.65	0.00			12.10	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	5.52	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	8,421	0			8,421	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	633	0			633	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	481	0			481	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	1,098	0			1,098	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	10,633	0			10,633	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	36,547	0			36,547	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	1,789	0			1,789	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	38,336	0			38,336	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	27.74	0.00			27.74	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0164		Period: From 04/01/2016 To 03/31/2017		Worksheet DSH Date/Time Prepared: 8/18/2017 2:58 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	16.65		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		16.65		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		16.65		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet DSH Date/Time Prepared: 8/18/2017 2:58 pm
		Title XVIII	Hospital	PPS

		Revised	
		Percentage	
		6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	12.10	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	12.10	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	12.10	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part B Date/Time Prepared: 8/18/2017 2:58 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		14,446	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		30,662,851	2.00
3.00	PPS payments		24,983,507	3.00
4.00	Outlier payment (see instructions)		389,973	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.872	5.00
6.00	Line 2 times line 5		26,738,006	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		94.90	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)		14,446	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		63,462	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)		63,462	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)		63,462	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		49,016	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		14,446	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		25,373,480	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,638,892	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)		20,749,034	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		234,507	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)		20,983,541	30.00
31.00	Primary payer payments		315	31.00
32.00	Subtotal (line 30 minus line 31)		20,983,226	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)		847,605	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		550,943	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		489,837	36.00
37.00	Subtotal (see instructions)		21,534,169	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		21,534,169	40.00
40.01	Sequestration adjustment (see instructions)		430,683	40.01
41.00	Interim payments		21,033,996	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		69,490	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
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0.112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet E-1
Part I
Date/Time Prepared:
8/18/2017 2:58 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		38,235,535		21,150,444	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		04/21/2016	59,826	11/08/2016	49,555	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		11/08/2016	84,530	04/21/2016	11,861	3.51	
3.52		03/14/2017	132,336	03/14/2017	154,142	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)		-157,040		-116,448	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)		38,078,495		21,033,996	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		216,017		69,490	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		38,294,512		21,103,486	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet E-1
Part II
Date/Time Prepared:
8/18/2017 2:58 pm

Title XVIII		Hospital	PPS
			1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		10,580 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		14,598 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		2,320 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		33,752 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		937,372,330 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		7,847,169 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)		491,119 8.00
9.00	Sequestration adjustment amount (see instructions)		9,822 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		481,297 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)		490,199 30.00
31.00	Other Adjustment (specify)		0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		-8,902 32.00
			Overrides
			1.00
CONTRACTOR OVERRIDES			
108.00	Override of HIT payment		0 108.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet E-4 Date/Time Prepared: 8/18/2017 2:58 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			15.80	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			15.80	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			16.64	6.00
7.00	Enter the lesser of line 5 or line 6			15.80	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	15.80	0.00	15.80	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	15.00	0.00	15.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	15.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	15.80	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	15.80	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	15.53	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	15.53	0.00		17.00
18.00	Per resident amount	82,873.85	0.00		18.00
19.00	Approved amount for resident costs	1,287,031	0	1,287,031	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.84	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,287,031	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	14,598	2,320		26.00
27.00	Total Inpatient Days (see instructions)	35,541	35,541		27.00
28.00	Ratio of inpatient days to total inpatient days	0.410737	0.065277		28.00
29.00	Program direct GME amount	528,631	84,014		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		11,871		30.00
31.00	Net Program direct GME amount			600,774	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet E-4 Date/Time Prepared: 8/18/2017 2:58 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		48,342,022	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		7,919	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		48,334,103	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		30,946,794	42.00
43.00	Primary payer payments (see instructions)		315	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		30,946,479	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		79,280,582	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.609659	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.390341	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		600,774	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		366,267	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		234,507	50.00

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

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet G
Date/Time Prepared:
8/18/2017 2:58 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	955,588	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	271,019,121	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-190,143,435	0	0	0	6.00
7.00	Inventory	7,469,390	0	0	0	7.00
8.00	Prepaid expenses	1,043,993	0	0	0	8.00
9.00	Other current assets	446,602	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)	90,791,259	0	0	0	11.00
FIXED ASSETS						
12.00	Land	7,001,998	0	0	0	12.00
13.00	Land improvements	5,898,209	0	0	0	13.00
14.00	Accumulated depreciation	-3,179,408	0	0	0	14.00
15.00	Buildings	158,593,963	0	0	0	15.00
16.00	Accumulated depreciation	-77,265,813	0	0	0	16.00
17.00	Leasehold improvements	192,105	0	0	0	17.00
18.00	Accumulated depreciation	-139,590	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	603,438	0	0	0	21.00
22.00	Accumulated depreciation	-343,947	0	0	0	22.00
23.00	Major movable equipment	75,283,741	0	0	0	23.00
24.00	Accumulated depreciation	-46,032,561	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	19,555,188	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	140,167,323	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	13,715,763	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	2,072,791	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,788,554	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	246,747,136	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	8,646,486	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,339,731	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,053,705	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	6,504,601	0	0	0	43.00
44.00	Other current liabilities	3,806,609	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,351,132	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	154,217,103	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	86,260	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	154,303,363	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	183,654,495	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	63,092,641				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)	63,092,641	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	246,747,136	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet G-1

Date/Time Prepared:
8/18/2017 2:58 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		41,322,160			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		21,770,484				2.00
3.00	Total (sum of line 1 and line 2)		63,092,644			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00	GRANT DEPOSIT	0		0		800,771	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		63,092,644			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	3		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00	WRITE OFF DONATION 2012	0		0		8	16.00
17.00	GRANT TRANSACTIONS	0		0		824,133	17.00
18.00	Total deductions (sum of lines 12-17)		3			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		63,092,641			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	23,370		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)	23,370		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00	GRANT DEPOSIT		0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	800,771		0			10.00
11.00	Subtotal (line 3 plus line 10)	824,141		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	ROUNDING		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00	WRITE OFF DONATION 2012		0				16.00
17.00	GRANT TRANSACTIONS		0				17.00
18.00	Total deductions (sum of lines 12-17)	824,141		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: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
8/18/2017 2:58 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	42,295,114		42,295,114	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	42,295,114		42,295,114	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,391,300		6,391,300	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	NEONATAL INTENSIVE CARE UNIT	9,340,388		9,340,388	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	15,731,688		15,731,688	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	58,026,802		58,026,802	17.00
18.00	Ancillary services	342,503,666	546,189,400	888,693,066	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	1,659,841	0	1,659,841	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	402,190,309	546,189,400	948,379,709	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		217,797,820		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)		217,797,820		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0164

Period:
From 04/01/2016
To 03/31/2017

Worksheet G-3

Date/Time Prepared:
8/18/2017 2:58 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	948,379,709	1.00
2.00	Less contractual allowances and discounts on patients' accounts	663,202,729	2.00
3.00	Net patient revenues (line 1 minus line 2)	285,176,980	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	217,797,820	4.00
5.00	Net income from service to patients (line 3 minus line 4)	67,379,160	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	679,118	6.00
7.00	Income from investments	4,505,082	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	23,071	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	1,220,481	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	2,815	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	76,125	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	19,742	21.00
22.00	Rental of hospital space	875,663	22.00
23.00	Governmental appropriations	1,534,287	23.00
24.00	GRANTS, MISCELLANEOUS	617,820	24.00
25.00	Total other income (sum of lines 6-24)	9,554,204	25.00
26.00	Total (line 5 plus line 25)	76,933,364	26.00
27.00	HOME OFFICE, LOSS ON EQUIP, CONTR TO	55,162,880	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	55,162,880	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	21,770,484	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0164	Period: From 04/01/2016 To 03/31/2017	Worksheet L Parts I-III Date/Time Prepared: 8/18/2017 2:58 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,641,140	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		71,983	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		97.37	3.00
4.00	Number of interns & residents (see instructions)		12.17	4.00
5.00	Indirect medical education percentage (see instructions)		3.59	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		94,817	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		5.52	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		27.74	8.00
9.00	Sum of lines 7 and 8		33.26	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.97	10.00
11.00	Disproportionate share adjustment (see instructions)		184,087	11.00
12.00	Total prospective capital payments (see instructions)		2,992,027	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0164

Period: From 04/01/2016

Worksheet M-1

Component CCN: 14-3454

To 03/31/2017

Date/Time Prepared: 8/18/2017 2:58 pm

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	136,133	0	136,133	0	136,133	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	25,865	0	25,865	0	25,865	9.00
10.00	Subtotal (sum of lines 1 through 9)	161,998	0	161,998	0	161,998	10.00
11.00	Physician Services Under Agreement	510,579	0	510,579	0	510,579	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	248,100	0	248,100	0	248,100	13.00
14.00	Subtotal (sum of lines 11 through 13)	758,679	0	758,679	0	758,679	14.00
15.00	Medical Supplies	0	104,811	104,811	-12,314	92,497	15.00
16.00	Transportation (Health Care Staff)	0	2,852	2,852	0	2,852	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	107,663	107,663	-12,314	95,349	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	920,677	107,663	1,028,340	-12,314	1,016,026	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	144,036	144,036	0	144,036	29.00
30.00	Administrative Costs	203,745	62,138	265,883	0	265,883	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	203,745	206,174	409,919	0	409,919	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,124,422	313,837	1,438,259	-12,314	1,425,945	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0164

Period: From 04/01/2016

Worksheet M-1

Component CCN: 14-3454

To 03/31/2017

Date/Time Prepared: 8/18/2017 2:58 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	136,133		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	25,865		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	161,998		10.00
11.00	Physician Services Under Agreement	0	510,579		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	248,100		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	758,679		14.00
15.00	Medical Supplies	0	92,497		15.00
16.00	Transportation (Health Care Staff)	0	2,852		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	95,349		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,016,026		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	144,036		29.00
30.00	Administrative Costs	-45,615	220,268		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-45,615	364,304		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-45,615	1,380,330		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0164 Component CCN: 14-3454	Period: From 04/01/2016 To 03/31/2017	Worksheet M-2 Date/Time Prepared: 8/18/2017 2:58 pm
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		RHC 1		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.00	0	2,100	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.00	0		0	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.00	0		0	8.00
9.00	Physician Services Under Agreements		11,772		11,772	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,016,026	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,016,026	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				364,304	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,186,232	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,550,536	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,550,536	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,550,536	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,566,562	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0164 Component CCN: 14-3454	Period: From 04/01/2016 To 03/31/2017	Worksheet M-3 Date/Time Prepared: 8/18/2017 2:58 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,566,562	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			107,874	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,458,688	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			0	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			11,772	5.00
6.00	Total adjusted visits (line 4 plus line 5)			11,772	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			208.86	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	2,472	832		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	201,023	68,474		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	269,497		16.00
16.01	Total program charges (see instructions)(from contractor's records)		380,502		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		186,989		16.04
16.05	Total program cost (see instructions)	0	186,989		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		35,761		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		68,936		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		186,989		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		49,614		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		236,603		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		236,603		26.00
26.01	Sequestration adjustment (see instructions)		4,732		26.01
27.00	Interim payments		181,470		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		50,401		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0164 Component CCN: 14-3454	Period: From 04/01/2016 To 03/31/2017	Worksheet M-4 Date/Time Prepared: 8/18/2017 2:58 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		161,998	161,998	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003950	0.012923	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		640	2,094	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		29,112	10,858	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		29,752	12,952	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,016,026	1,016,026	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,550,536	1,550,536	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.029283	0.012748	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		45,404	19,766	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		75,156	32,718	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		206	674	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		364.83	48.54	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		101	263	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		36,848	12,766	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			107,874	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			49,614	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0164 Component CCN: 14-3454	Period: From 04/01/2016 To 03/31/2017	Worksheet M-5 Date/Time Prepared: 8/18/2017 2:58 pm
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		181,470	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	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		181,470	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		50,401	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		231,871	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)
		0	1.00	2.00
8.00	Name of Contractor			8.00