

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 04/01/2017 To 03/31/2018	Worksheet S Parts I-III Date/Time Prepared: 8/28/2018 9:33 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 8/28/2018	Time: 9:33 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL OF CARBONDALE (14-0164) for the cost reporting period beginning 04/01/2017 and ending 03/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	444,181	490,426	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		28,886		0	10.00
200.00 Total	0	444,181	519,312	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0164		Period: From 04/01/2017 To 03/31/2018		Worksheet S-2 Part I Date/Time Prepared: 8/28/2018 9:29 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 405 W. JACKSON			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)					04/01/2017		03/31/2018		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.	7,882	1,381	0	0	273	879			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 04/01/2017 To 03/31/2018	Worksheet S-2 Part I Date/Time Prepared: 8/28/2018 9:29 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		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)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N		40.00	
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	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		46.00	
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.		N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		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	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N	0.00		61.00	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03	

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							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)						62.00	0.00
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) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00	Y
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
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)						64.00	0.00 0.00 0.000000

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	SOUTHERN ILLINOIS FAMILY MEDICINE	1350	9.77	4.69	0.675657	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	SOUTHERN ILLINOIS FAMILY MEDICINE	1350	10.93	4.73	0.697957	67.00	
				1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part I Date/Time Prepared: 8/28/2018 9:29 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	1,255,415	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part I Date/Time Prepared: 8/28/2018 9:29 am			
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: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101			
142.00	Street: 1239 E. MAIN ST.	PO Box: 3988					
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988			
144.00 Are provider based physicians' costs included in Worksheet A?							
				1.00	Y		
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							
				1.00	N		
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.							
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							
				1.00	N		
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							
				1.00	N		
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							
				1.00	N		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
155.00	Hospital	N	N	N	N		
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		
Multi campus							
165.00 Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							
				1.00	N		
		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
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							
				1.00	Y		
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)							
				1.00	0		
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							
				1.00			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							
				1.00	0.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							
				1.00	10/01/2017	2.00	12/31/2017
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							
				1.00	N	0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0164		Period: From 04/01/2017 To 03/31/2018		Worksheet S-2 Part II Date/Time Prepared: 8/28/2018 9:29 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		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			
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	07/03/2018	Y	07/03/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part II Date/Time Prepared: 8/28/2018 9:29 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		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			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			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.			Y	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.	SOUTHERN ILLINOIS 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 04/01/2017 To 03/31/2018	Worksheet S-2 Part II Date/Time Prepared: 8/28/2018 9:29 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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 04/01/2017 To 03/31/2018	Worksheet S-2 Part IX Date/Time Prepared: 8/28/2018 9:29 am
		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. (see S-2, Part I, line 98)	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. (see S-2, Part I, line 98.01)	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. (see S-2, Part I, line 98.02)	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. (see S-2, Part I, lines 98.03 and 98.04)	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. (see S-2, Part I, lines 98.03 and 98.04)	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. (see S-2, Part I, line 98.05)	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. (see S-2, Part I, line 98.06)	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
FQHC				
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 04/01/2017
To 03/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
8/28/2018 9:29 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	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	21	7,665	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)		167	60,955	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)		167				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
8/28/2018 9:29 am

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)	13,123	5,266	27,898			1.00
2.00 HMO and other (see instructions)	2,194	1,152				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)	13,123	5,266	27,898			7.00
8.00 INTENSIVE CARE UNIT	3,396	899	6,253			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	1,015	1,444			12.00
13.00 NURSERY		1,292	2,568			13.00
14.00 Total (see instructions)	16,519	8,472	38,163	13.30	1,150.17	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	3,101	3,085	13,255	2.36	11.47	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)				15.66	1,161.64	27.00
28.00 Observation Bed Days		852	3,757			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	793	1,698			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			584			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
8/28/2018 9:29 am

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	4,079	2,640	11,049	1.00
2.00 HMO and other (see instructions)			545	411		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	4,079	2,640	11,049	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			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet S-3
Part II
Date/Time Prepared:
8/28/2018 9:29 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	67,510,268	0	67,510,268	2,416,216.86	27.94
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		671,956	0	671,956	29,091.86	23.10
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	1,110,735	0	1,110,735	38,710.00	28.69
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		4,770,442	0	4,770,442	72,519.71	65.78
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		451,205	0	451,205	2,489.00	181.28
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		11,472,821	0	11,472,821	342,632.96	33.48
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)		15,411,523	0	15,411,523		
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		60,766	0	60,766		
24.00	Wage-related costs (RHC/FQHC)		97,544	0	97,544		
25.00	Interns & residents (in an approved program)		260,453	0	260,453		
25.50	Home office wage-related (core)		4,196,337	0	4,196,337		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	175,310	0	175,310	4,583.16	38.25
27.00	Administrative & General	5.00	5,969,261	0	5,969,261	162,087.06	36.83

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet S-3
Part II
Date/Time Prepared:
8/28/2018 9:29 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,647,550	0	1,647,550	3,774.10	436.54	28.00
29.00	Maintenance & Repairs	6.00	640,377	0	640,377	29,445.45	21.75	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	83,593	0	83,593	5,914.15	14.13	31.00
32.00	Housekeeping	9.00	1,688,447	0	1,688,447	122,082.69	13.83	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,516,604	-1,137,081	379,523	24,022.29	15.80	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,137,081	1,137,081	71,990.07	15.79	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	829,989	0	829,989	17,562.91	47.26	38.00
39.00	Central Services and Supply	14.00	347,977	0	347,977	23,517.14	14.80	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	575,128	0	575,128	32,239.14	17.84	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet S-3
Part III
Date/Time Prepared:
8/28/2018 9:29 am

	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)	67,375,127	0	67,375,127	2,352,189.10	28.64	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)	67,375,127	0	67,375,127	2,352,189.10	28.64	3.00
4.00	Subtotal other wages & related costs (see inst.)	16,694,468	0	16,694,468	417,641.67	39.97	4.00
5.00	Subtotal wage-related costs (see inst.)	19,607,860	0	19,607,860	0.00	29.10	5.00
6.00	Total (sum of lines 3 thru 5)	103,677,455	0	103,677,455	2,769,830.77	37.43	6.00
7.00	Total overhead cost (see instructions)	13,474,236	0	13,474,236	497,218.16	27.10	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 8/28/2018 9:29 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,107,259	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,852,067	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	157,511	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	18,613	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)	191,725	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	552,376	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	885,702	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,861,147	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	45,524	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	158,362	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,830,286	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 04/01/2017 To 03/31/2018	Worksheet S-3 Part V Date/Time Prepared: 8/28/2018 9:29 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	4,770,442	15,830,286	1.00
2.00	Hospital	4,770,442	15,412,268	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	97,544	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	320,474	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0164 Component CCN: 14-3454		Period: From 04/01/2017 To 03/31/2018		Worksheet S-8 Date/Time Prepared: 8/28/2018 9:29 am	
		RHC I		Cost			
				1.00			
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	2.00	City, State, ZIP Code, County		WEST FRANKFORT IL		62896 2.00	
				1.00			
3.00	3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		Grant Award		Date	
				1.00		2.00	
4.00	4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)					
5.00	5.00	Migrant Health Center (Section 329(d), PHS Act)					
6.00	6.00	Health Services for the Homeless (Section 340(d), PHS Act)					
7.00	7.00	Appalachian Regional Commission					
8.00	8.00	Look-Alikes					
9.00	9.00	OTHER (SPECIFY)					
				1.00		2.00	
10.00	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	
				Sunday		Monday	
				Tuesday			
				from		to	
				1.00		2.00	
				3.00		4.00	
				5.00			
11.00	11.00	Facility hours of operations (1) CLINIC		08:00		17:00	
				08:00			
				1.00		2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N			
13.00	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	
				Provider name		CCN number	
				1.00		2.00	
14.00	14.00	RHC/FQHC name, CCN number					
				Y/N		V	
				1.00		2.00	
				XVIII		XIX	
				3.00		4.00	
				Total Visits		5.00	
15.00	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)					
				County		4.00	
2.00	2.00	City, State, ZIP Code, County		FRANKLIN			
				Tuesday		Wednesday	
				Thursday			
				to		from	
				6.00		7.00	
				8.00		9.00	
				10.00			
11.00	11.00	Facility hours of operations (1) CLINIC		17:00		08:00	
				17:00		08:00	
				17:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0164 Component CCN: 14-3454		Period: From 04/01/2017 To 03/31/2018		Worksheet S-8 Date/Time Prepared: 8/28/2018 9:29 am	
				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	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet S-10 Date/Time Prepared: 8/28/2018 9:29 am
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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)		0.229750	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		24,889,910	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		10,590,453	5.00
6.00	Medicaid charges		204,814,403	6.00
7.00	Medicaid cost (line 1 times line 6)		47,056,109	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)		11,575,746	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		428,869	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		11,575,746	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,566,230	3,899,796	9,466,026
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,278,841	3,899,796	5,178,637
22.00	Payments received from patients for amounts previously written off as charity care	1,206	21,687	22,893
23.00	Cost of charity care (line 21 minus line 22)	1,277,635	3,878,109	5,155,744
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		10,161,763	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,937,465	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,980,716	27.01
28.00	Non-Medicare bad debt expense (see instructions)		7,181,047	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,693,097	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,848,841	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		19,424,587	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet A
Date/Time Prepared:
8/28/2018 9:29 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		7,368,184	7,368,184	693,673	8,061,857	1.00
2.00	00200		7,336,738	7,336,738	278,210	7,614,948	2.00
4.00	00400						
		175,310	21,668,307	21,843,617	0	21,843,617	4.00
5.01	00550	0	0	0	0	0	5.01
5.02	00560	386,069	124,118	510,187	0	510,187	5.02
5.03	00580	673,064	35,819	708,883	0	708,883	5.03
5.04	00590	4,910,128	11,543,731	16,453,859	-846	16,453,013	5.04
6.00	00600	640,377	1,788,760	2,429,137	0	2,429,137	6.00
8.00	00800	83,593	1,382,590	1,466,183	0	1,466,183	8.00
9.00	00900	1,688,447	506,714	2,195,161	0	2,195,161	9.00
10.00	01000	1,516,604	1,369,511	2,886,115	-2,180,571	705,544	10.00
11.00	01100	0	0	0	2,163,878	2,163,878	11.00
13.00	01300	829,989	56,427	886,416	0	886,416	13.00
14.00	01400	347,977	111,598	459,575	-38,898	420,677	14.00
16.00	01600	575,128	79,858	654,986	0	654,986	16.00
19.00	01900	0	0	0	5,450,475	5,450,475	19.00
21.00	02100	1,110,735	0	1,110,735	0	1,110,735	21.00
22.00	02200	0	1,376,727	1,376,727	0	1,376,727	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	14,160,732	11,846,042	26,006,774	-177,566	25,829,208	30.00
31.00	03100	4,494,123	1,864,174	6,358,297	-116,380	6,241,917	31.00
35.00	02060	823,282	170,463	993,745	-4,550	989,195	35.00
43.00	04300	0	139,977	139,977	-3,776	136,201	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,179,770	17,918,059	22,097,829	-10,688,080	11,409,749	50.00
50.01	05001	1,402,613	767,929	2,170,542	-2,170,542	0	50.01
51.00	05100	704,213	84,974	789,187	-5,072	784,115	51.00
52.00	05200	3,626,362	764,950	4,391,312	-93,392	4,297,920	52.00
53.00	05300	699,033	6,150,990	6,850,023	-5,634,437	1,215,586	53.00
54.00	05400	2,638,400	2,398,635	5,037,035	-948,080	4,088,955	54.00
54.01	03480	853,771	1,778,129	2,631,900	-16,312	2,615,588	54.01
54.02	03440	646,159	680,707	1,326,866	-6,037	1,320,829	54.02
56.00	05600	295,364	1,238,900	1,534,264	144,836	1,679,100	56.00
58.00	05800	312,799	248,180	560,979	-83,987	476,992	58.00
59.00	05900	3,658,373	13,150,047	16,808,420	-10,530,209	6,278,211	59.00
60.00	06000	2,279,370	6,235,421	8,514,791	-53,461	8,461,330	60.00
64.00	06400	782,435	360,845	1,143,280	-54,001	1,089,279	64.00
65.00	06500	1,436,854	419,053	1,855,907	-127,853	1,728,054	65.00
66.00	06600	2,559,207	824,993	3,384,200	0	3,384,200	66.00
69.00	06900	1,338,432	8,118,085	9,456,517	-621,729	8,834,788	69.00
70.00	07000	103,396	125,946	229,342	-11,991	217,351	70.00
71.00	07100	0	0	0	10,472,229	10,472,229	71.00
72.00	07200	0	0	0	14,260,831	14,260,831	72.00
73.00	07300	3,062,743	21,571,555	24,634,298	1,169,043	25,803,341	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	415,990	1,027,168	1,443,158	-13,706	1,429,452	88.00
91.00	09100	4,099,426	7,000,613	11,100,039	-79,816	11,020,223	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		4,544,595	4,544,595	-971,883	3,572,712	113.00
118.00		67,510,268	164,179,512	231,689,780	0	231,689,780	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	94,340	94,340	0	94,340	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
200.00		67,510,268	164,273,852	231,784,120	0	231,784,120	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet A
Date/Time Prepared:
8/28/2018 9:29 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-311,200	7,750,657	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,863,044	14,477,992	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	230,382	22,073,999	4.00
5.01	00550	DATA PROCESSING	9,653,394	9,653,394	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-49,605	460,582	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,842,538	4,551,421	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,613,630	19,066,643	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	2,429,137	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,466,183	8.00
9.00	00900	HOUSEKEEPING	-55	2,195,106	9.00
10.00	01000	DIETARY	0	705,544	10.00
11.00	01100	CAFETERIA	-1,303,971	859,907	11.00
13.00	01300	NURSING ADMINISTRATION	0	886,416	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	420,677	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-96,260	558,726	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-5,450,475	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,110,735	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-957	1,375,770	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,595,211	20,233,997	30.00
31.00	03100	INTENSIVE CARE UNIT	-9,676	6,232,241	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	989,195	35.00
43.00	04300	NURSERY	0	136,201	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-54,841	11,354,908	50.00
50.01	05001	SAME DAY SURGERY	0	0	50.01
51.00	05100	RECOVERY ROOM	0	784,115	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-32,901	4,265,019	52.00
53.00	05300	ANESTHESIOLOGY	0	1,215,586	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-9,595	4,079,360	54.00
54.01	03480	ONCOLOGY	-604,309	2,011,279	54.01
54.02	03440	MAMMOGRAPHY	-43,410	1,277,419	54.02
56.00	05600	RADIOISOTOPE	0	1,679,100	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	476,992	58.00
59.00	05900	CARDIAC CATHETERIZATION	-157,171	6,121,040	59.00
60.00	06000	LABORATORY	-277,357	8,183,973	60.00
64.00	06400	INTRAVENOUS THERAPY	-11,014	1,078,265	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,728,054	65.00
66.00	06600	PHYSICAL THERAPY	-80,650	3,303,550	66.00
69.00	06900	ELECTROCARDIOLOGY	-41,168	8,793,620	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	217,351	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,472,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,260,831	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,803,341	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-33,564	1,395,888	88.00
91.00	09100	EMERGENCY	-5,954,182	5,066,041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-3,572,712	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-487,296	231,202,484	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	94,340	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 through 199)	-487,296	231,296,824	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet Non-CMS W
Date/Time Prepared:
8/28/2018 9:29 am

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	RADIOLOGY	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 through 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 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet A-6

Date/Time Prepared:
8/28/2018 9:29 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - DIETARY RECLASS						
1.00	CAFETERIA	11.00	1,137,081	1,026,797	1.00	
	TOTALS		1,137,081	1,026,797		
B - NUTRITIONAL PRODUCT RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	495,336	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	495,336		
C - MEDICAL SUPPLY RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	24,733,060	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	
	TOTALS		0	24,733,060		
D - SAME DAY SURGERY RECLASS						
1.00	OPERATING ROOM	50.00	1,402,613	767,929	1.00	
	TOTALS		1,402,613	767,929		
E - INTEREST RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	693,673	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	278,210	2.00	
	TOTALS		0	971,883		
F - IMPLANTABLE DEVICE RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,260,831	1.00	
	TOTALS		0	14,260,831		
G - CRNA RECLASS						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	5,450,475	1.00	
	TOTALS		0	5,450,475		
H - CONTRAST DRUG RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	673,707	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	673,707		
I - ISOTOPE RECLASS						
1.00	RADIOISOTOPE	56.00	0	145,085	1.00	
	TOTALS		0	145,085		
500.00	Grand Total: Increases		2,539,694	48,525,103	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet A-6
Date/Time Prepared:
8/28/2018 9:29 am

		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	1,137,081	1,026,797	0		1.00
	TOTALS		1,137,081	1,026,797			
B - NUTRITIONAL PRODUCT RECLASS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	270	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	156,576	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	44,053	0		3.00
4.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	3,975	0		4.00
5.00	NURSERY	43.00	0	3,748	0		5.00
6.00	OPERATING ROOM	50.00	0	40,432	0		6.00
7.00	RECOVERY ROOM	51.00	0	5,072	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	38,773	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	48,888	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,374	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	25,829	0		11.00
12.00	RADIOISOTOPE	56.00	0	153	0		12.00
13.00	LABORATORY	60.00	0	131	0		13.00
14.00	INTRAVENOUS THERAPY	64.00	0	44,039	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	1,320	0		15.00
16.00	EMERGENCY	91.00	0	54,123	0		16.00
17.00	MAMMOGRAPHY	54.02	0	887	0		17.00
18.00	DIETARY	10.00	0	16,693	0		18.00
	TOTALS		0	495,336			
C - MEDICAL SUPPLY RECLASS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	38,628	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	20,990	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	72,327	0		3.00
4.00	NURSERY	43.00	0	28	0		4.00
5.00	OPERATING ROOM	50.00	0	12,811,686	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	54,619	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	135,074	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	867,410	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	288	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	10,409,444	0		10.00
11.00	LABORATORY	60.00	0	53,330	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	127,853	0		12.00
13.00	EMERGENCY	91.00	0	25,693	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	57,052	0		14.00
15.00	ELECTROENCEPHALOGRAPHY	70.00	0	11,991	0		15.00
16.00	MAMMOGRAPHY	54.02	0	5,150	0		16.00
17.00	ONCOLOGY	54.01	0	16,312	0		17.00
18.00	RURAL HEALTH CLINIC	88.00	0	13,706	0		18.00
19.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	846	0		19.00
20.00	INTRAVENOUS THERAPY	64.00	0	9,962	0		20.00
21.00	RADIOISOTOPE	56.00	0	96	0		21.00
22.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	575	0		22.00
	TOTALS		0	24,733,060			
D - SAME DAY SURGERY RECLASS							
1.00	SAME DAY SURGERY	50.01	1,402,613	767,929	0		1.00
	TOTALS		1,402,613	767,929			
E - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	971,883	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	971,883			
F - IMPLANTABLE DEVICE RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	14,260,831	0		1.00
	TOTALS		0	14,260,831			
G - CRNA RECLASS							
1.00	ANESTHESIOLOGY	53.00	0	5,450,475	0		1.00
	TOTALS		0	5,450,475			
H - CONTRAST DRUG RECLASS							
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	83,699	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	418,272	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	70,296	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	94,936	0		4.00
5.00	OPERATING ROOM	50.00	0	6,504	0		5.00
	TOTALS		0	673,707			

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet A-6
Date/Time Prepared:
8/28/2018 9:29 am

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	145,085	0	1.00
	TOTALS		0	145,085		
500.00	Grand Total: Decreases		2,539,694	48,525,103		500.00

RECLASSIFICATIONS

Provider CCN: 14-0164

Period: From 04/01/2017 To 03/31/2018

Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 8/28/2018 9:29 am

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	1,137,081	1,026,797	DIETARY	10.00	1,137,081	1,026,797	1.00
	TOTALS		1,137,081	1,026,797	TOTALS		1,137,081	1,026,797	
B - NUTRITIONAL PRODUCT RECLASS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	495,336	CENTRAL SERVICES & SUPPLY	14.00	0	270	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	156,576	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	44,053	3.00
4.00		0.00	0	0	NEONATAL INTENSIVE CARE UNIT	35.00	0	3,975	4.00
5.00		0.00	0	0	NURSERY	43.00	0	3,748	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	40,432	6.00
7.00		0.00	0	0	RECOVERY ROOM	51.00	0	5,072	7.00
8.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	38,773	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	48,888	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	10,374	10.00
11.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	25,829	11.00
12.00		0.00	0	0	RADIOISOTOPE	56.00	0	153	12.00
13.00		0.00	0	0	LABORATORY	60.00	0	131	13.00
14.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	44,039	14.00
15.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	1,320	15.00
16.00		0.00	0	0	EMERGENCY	91.00	0	54,123	16.00
17.00		0.00	0	0	MAMMOGRAPHY	54.02	0	887	17.00
18.00		0.00	0	0	DIETARY	10.00	0	16,693	18.00
	TOTALS		0	495,336	TOTALS		0	495,336	
C - MEDICAL SUPPLY RECLASS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	24,733,060	CENTRAL SERVICES & SUPPLY	14.00	0	38,628	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	20,990	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	72,327	3.00
4.00		0.00	0	0	NURSERY	43.00	0	28	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	12,811,686	5.00
6.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	54,619	6.00
7.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	135,074	7.00
8.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	867,410	8.00
9.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	288	9.00
10.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	10,409,444	10.00
11.00		0.00	0	0	LABORATORY	60.00	0	53,330	11.00
12.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	127,853	12.00
13.00		0.00	0	0	EMERGENCY	91.00	0	25,693	13.00
14.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	57,052	14.00
15.00		0.00	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	11,991	15.00
16.00		0.00	0	0	MAMMOGRAPHY	54.02	0	5,150	16.00
17.00		0.00	0	0	ONCOLOGY	54.01	0	16,312	17.00
18.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	13,706	18.00
19.00		0.00	0	0	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	846	19.00
20.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	9,962	20.00
21.00		0.00	0	0	RADIOISOTOPE	56.00	0	96	21.00
22.00		0.00	0	0	NEONATAL INTENSIVE CARE UNIT	35.00	0	575	22.00
	TOTALS		0	24,733,060	TOTALS		0	24,733,060	
D - SAME DAY SURGERY RECLASS									
1.00	OPERATING ROOM	50.00	1,402,613	767,929	SAME DAY SURGERY	50.01	1,402,613	767,929	1.00
	TOTALS		1,402,613	767,929	TOTALS		1,402,613	767,929	
E - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	693,673	INTEREST EXPENSE	113.00	0	971,883	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	278,210		0.00	0	0	2.00
	TOTALS		0	971,883	TOTALS		0	971,883	
F - IMPLANTABLE DEVICE RECLASS									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,260,831	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	14,260,831	1.00
	TOTALS		0	14,260,831	TOTALS		0	14,260,831	
G - CRNA RECLASS									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	5,450,475	ANESTHESIOLOGY	53.00	0	5,450,475	1.00
	TOTALS		0	5,450,475	TOTALS		0	5,450,475	

RECLASSIFICATIONS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/28/2018 9:29 am

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	
H - CONTRAST DRUG RECLASS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	673,707	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	83,699	1.00
2.00		0.00	0		ELECTROCARDIOLOGY	69.00	0	418,272	2.00
3.00		0.00	0		RADIOLOGY-DIAGNOSTIC	54.00	0	70,296	3.00
4.00		0.00	0		CARDIAC CATHETERIZATION	59.00	0	94,936	4.00
5.00		0.00	0		OPERATING ROOM	50.00	0	6,504	5.00
	TOTALS		0	673,707	TOTALS		0	673,707	
I - ISOTOPE RECLASS									
1.00	RADIOISOTOPE	56.00	0	145,085	ELECTROCARDIOLOGY	69.00	0	145,085	1.00
	TOTALS		0	145,085	TOTALS		0	145,085	
500.00	Grand Total : Increases		2,539,694	48,525,103	Grand Total : Decreases		2,539,694	48,525,103	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet A-7
Part I
Date/Time Prepared:
8/28/2018 9:29 am

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,001,998	540,357	0	540,357	0	1.00
2.00	Land Improvements	5,898,209	58,980	0	58,980	0	2.00
3.00	Buildings and Fixtures	158,786,068	28,232,354	0	28,232,354	2,000	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	75,887,179	7,249,206	0	7,249,206	3,751,909	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	247,573,454	36,080,897	0	36,080,897	3,753,909	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	247,573,454	36,080,897	0	36,080,897	3,753,909	10.00
	Ending Balance		Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,542,355	0				1.00
2.00	Land Improvements	5,957,189	0				2.00
3.00	Buildings and Fixtures	187,016,422	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	79,384,476	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	279,900,442	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	279,900,442	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet A-7
Part II
Date/Time Prepared:
8/28/2018 9:29 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	7,368,184	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,336,738	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,704,922	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	7,368,184				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,336,738				2.00
3.00	Total (sum of lines 1-2)	0	14,704,922				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet A-7
Part III
Date/Time Prepared:
8/28/2018 9:29 am

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	200,515,968	0	200,515,968	0.716383	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	79,384,476	0	79,384,476	0.283617	0	2.00
3.00	Total (sum of lines 1-2)	279,900,444	0	279,900,444	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	7,750,657	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	14,477,992	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	22,228,649	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	7,750,657	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	14,477,992	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	22,228,649	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet A-8

Date/Time Prepared:
8/28/2018 9:29 am

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
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	-13,065,539				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	41,200,944				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,282,953	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	-66,573	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-21,018	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	-5,450,475	NONPHYSICIAN ANESTHETISTS		19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
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

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.00
33.01 EMPLOYEE OUTPATIENT PAYMENTS	B	-5,707,619	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.01
33.02 DEBT FORGIVENESS	A	-202,389	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.02
33.03 INTEREST INCOME UNRESTRICTED	B	-4,374,600	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.03
33.04 LOSS ON 1994 BONDS	A	93,579	CAP REL COSTS-BLDG & FIXT		1.00	9	33.04
33.05 LOSS ON 1994 BONDS	A	80,262	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.05
33.06 FUNDED DEPRECIATION	A	-4,035	CAP REL COSTS-BLDG & FIXT		1.00	9	33.06
33.07 NONALLOWABLE BOND EXPENSE	A	-3,572,712	INTEREST EXPENSE		113.00	0	33.07
33.08 MISCELLANEOUS INCOME	B	-1,125	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.08
33.09 SALE OF XRAY SILVER/FILM	B	-2,945	RADIOLOGY-DIAGNOSTIC		54.00	0	33.09
33.10 OFFSET LOBBYING EXPENSES	A	-30,696	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.10
33.11 PURCHASE DISCOUNT	B	-48,360	PURCHASING RECEIVING AND STORES		5.02	0	33.11
33.12 LOSS ON 1991 BONDS	A	116,930	CAP REL COSTS-BLDG & FIXT		1.00	9	33.12
33.13 LOSS ON 1991 BONDS	A	80,021	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.13
33.14 LEASEHOLD REVENUE	B	-35,903	MAMMOGRAPHY		54.02	0	33.14
33.15 VENDING MACHINE INCOME	B	-55	HOUSEKEEPING		9.00	0	33.15
33.16 PATIENT'S GUEST LODGING EXPENSE	A	-74,500	CARDIAC CATHETERIZATION		59.00	0	33.16
33.17 LEASEHOLD REVENUE	B	-839,404	CAP REL COSTS-BLDG & FIXT		1.00	9	33.17
33.18 MEDICAID PROVIDER TAX	A	-7,240,493	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.18
33.19 CABLE TV	A	-957	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00	0	33.19
33.20 SALE OF MEDICAL RECORDS AND ABSTRACT	B	-740	RURAL HEALTH CLINIC		88.00	0	33.20
33.21 MISCELLANEOUS INCOME	B	-30,364	RURAL HEALTH CLINIC		88.00	0	33.21
33.22 INTEREST INCOME UNRESTRICTED	B	-2,460	RURAL HEALTH CLINIC		88.00	0	33.22
33.23 VENDING MACHINE INCOME	B	-1,072	ELECTROCARDIOLOGY		69.00	0	33.23
33.24 DEPARTMENTAL PROGRAM REVENUE	B	-800	ELECTROCARDIOLOGY		69.00	0	33.24
33.25 CABLE TV	A	-1,245	PURCHASING RECEIVING AND STORES		5.02	0	33.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-487,296					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 04/01/2017 To 03/31/2018

Worksheet A-8-1

Date/Time Prepared: 8/28/2018 9:29 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	321,730	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	6,702,761	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	5,938,001	0
4.00	5.01	DATA PROCESSING	HOME OFFICE	9,653,394	0
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	3,842,538	0
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	14,875,042	0
4.03	66.00	PHYSICAL THERAPY	RENT	70,442	151,092
4.04	5.04	OTHER ADMINISTRATIVE AND GEN	RENT	5,355	12,732
4.05	16.00	MEDICAL RECORDS & LIBRARY	RENT	21,541	51,228
4.06	54.00	RADIOLOGY-DIAGNOSTIC	RENT	4,822	11,472
4.07	60.00	LABORATORY	RENT	7,067	15,225
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			41,442,693	241,749

* 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	HOME OFFICE	100.00	6.00
7.00	B	SIHE	100.00	RELATED ORG	100.00	7.00
8.00	B	HSSI	100.00	RELATED ORG	100.00	8.00
9.00	B	SIMS	100.00	RELATED ORG	100.00	9.00
10.00	B	SIH CAYMAN SPC	100.00	RELATED ORG	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 04/01/2017
To 03/31/2018

Worksheet A-8-1

Date/Time Prepared:
8/28/2018 9:29 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	321,730	9		1.00
2.00	6,702,761	9		2.00
3.00	5,938,001	0		3.00
4.00	9,653,394	0		4.00
4.01	3,842,538	0		4.01
4.02	14,875,042	0		4.02
4.03	-80,650	0		4.03
4.04	-7,377	0		4.04
4.05	-29,687	0		4.05
4.06	-6,650	0		4.06
4.07	-8,158	0		4.07
5.00	41,200,944			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 04/01/2017
To 03/31/2018

Worksheet A-8-2

Date/Time Prepared:
8/28/2018 9:29 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	5,595,211	5,595,211	0	0	0	1.00
2.00	31.00	DR. B	44,655	0	44,655	211,500	344	2.00
3.00	50.00	DR. C	67,436	54,841	12,595	246,400	113	3.00
4.00	54.02	DR. D	38,880	0	38,880	271,900	240	4.00
5.00	59.00	DR. E	129,343	0	129,343	211,500	459	5.00
6.00	60.00	DR. F	269,199	269,199	0	0	0	6.00
7.00	54.01	DR. G	679,859	547,561	132,298	211,500	743	7.00
8.00	69.00	DR. H	39,296	39,296	0	0	0	8.00
9.00	91.00	DR. I	5,970,917	5,944,455	26,462	181,300	192	9.00
10.00	5.04	DR. J	404,732	404,732	0	0	0	10.00
11.00	52.00	DR. K	63,223	20,687	42,536	237,100	266	11.00
12.00	64.00	DR. L	24,436	0	24,436	211,500	132	12.00
200.00			13,327,187	12,875,982	451,205		2,489	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	34,979	1,749	0	0	0	2.00
3.00	50.00	DR. C	13,386	669	0	0	0	3.00
4.00	54.02	DR. D	31,373	1,569	0	0	0	4.00
5.00	59.00	DR. E	46,672	2,334	0	0	0	5.00
6.00	60.00	DR. F	0	0	0	0	0	6.00
7.00	54.01	DR. G	75,550	3,778	0	0	0	7.00
8.00	69.00	DR. H	0	0	0	0	0	8.00
9.00	91.00	DR. I	16,735	837	0	0	0	9.00
10.00	5.04	DR. J	0	0	0	0	0	10.00
11.00	52.00	DR. K	30,322	1,516	0	0	0	11.00
12.00	64.00	DR. L	13,422	671	0	0	0	12.00
200.00			262,439	13,123	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	5,595,211	1.00
2.00	31.00	DR. B	0	34,979	9,676	9,676	2.00
3.00	50.00	DR. C	0	13,386	0	54,841	3.00
4.00	54.02	DR. D	0	31,373	7,507	7,507	4.00
5.00	59.00	DR. E	0	46,672	82,671	82,671	5.00
6.00	60.00	DR. F	0	0	0	269,199	6.00
7.00	54.01	DR. G	0	75,550	56,748	604,309	7.00
8.00	69.00	DR. H	0	0	0	39,296	8.00
9.00	91.00	DR. I	0	16,735	9,727	5,954,182	9.00
10.00	5.04	DR. J	0	0	0	404,732	10.00
11.00	52.00	DR. K	0	30,322	12,214	32,901	11.00
12.00	64.00	DR. L	0	13,422	11,014	11,014	12.00
200.00			0	262,439	189,557	13,065,539	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet B
Part I
Date/Time Prepared:
8/28/2018 9:29 am

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			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,750,657	7,750,657			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	14,477,992		14,477,992		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	22,073,999	20,929	5,569	22,100,497	4.00
5.01 00550	DATA PROCESSING	9,653,394	36,829	0	0	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	460,582	61,206	353	126,714	5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	4,551,421	59,117	0	220,911	5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	19,066,643	1,811,307	648,253	1,611,587	5.04
6.00 00600	MAINTENANCE & REPAIRS	2,429,137	853,867	2,096	210,183	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,466,183	18,719	0	27,437	8.00
9.00 00900	HOUSEKEEPING	2,195,106	61,997	5,131	554,177	9.00
10.00 01000	DIETARY	705,544	90,289	34,226	124,566	10.00
11.00 01100	CAFETERIA	859,907	100,469	1,902	373,209	11.00
13.00 01300	NURSING ADMINISTRATION	886,416	73,314	658,264	272,416	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	420,677	71,732	1,731	114,212	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	558,726	0	7,122	188,767	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,110,735	0	0	364,562	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,375,770	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	20,233,997	1,409,166	455,441	4,647,814	30.00
31.00 03100	INTENSIVE CARE UNIT	6,232,241	258,190	276,637	1,475,048	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	989,195	37,681	144,763	270,215	35.00
43.00 04300	NURSERY	136,201	18,536	2,246	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	11,354,908	651,955	3,548,983	1,832,233	50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	50.01
51.00 05100	RECOVERY ROOM	784,115	56,015	67,303	231,135	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,265,019	196,923	149,728	1,190,234	52.00
53.00 05300	ANESTHESIOLOGY	1,215,586	8,579	54,198	229,435	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,079,360	175,831	1,202,080	865,968	54.00
54.01 03480	ONCOLOGY	2,011,279	188,020	1,526,547	280,222	54.01
54.02 03440	MAMMOGRAPHY	1,277,419	0	468,998	212,080	54.02
56.00 05600	RADIOISOTOPE	1,679,100	36,302	15,785	96,943	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	476,992	43,380	1,352,876	102,666	58.00
59.00 05900	CARDIAC CATHETERIZATION	6,121,040	266,607	2,200,148	1,200,740	59.00
60.00 06000	LABORATORY	8,183,973	184,248	604,569	748,128	60.00
64.00 06400	INTRAVENOUS THERAPY	1,078,265	85,563	59,895	256,808	64.00
65.00 06500	RESPIRATORY THERAPY	1,728,054	32,124	74,692	471,600	65.00
66.00 06600	PHYSICAL THERAPY	3,303,550	31,719	24,728	839,975	66.00
69.00 06900	ELECTROCARDIOLOGY	8,793,620	44,536	390,395	439,296	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	217,351	11,256	34,944	33,936	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,472,229	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	14,260,831	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	25,803,341	49,870	47,917	1,005,244	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,395,888	0	6,982	136,535	88.00
91.00 09100	EMERGENCY	5,066,041	204,123	403,490	1,345,501	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 through 117)	231,202,484	7,250,399	14,477,992	22,100,497	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,441	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	94,340	135,960	0	0	192.00
192.01 19201	FAMILY PRACTICE	0	0	0	0	192.01
192.02 19202	UNUSED SPACE	0	320,857	0	0	192.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	231,296,824	7,750,657	14,477,992	22,100,497	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0164

Period: From 04/01/2017 To 03/31/2018

Worksheet B Part I Date/Time Prepared: 8/28/2018 9:29 am

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	738,806				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,790	5,070,384			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	135	0	23,972,020	23,972,020	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	3,658,831	423,052	4,081,883
8.00	00800	LAUNDRY & LINEN SERVICE	519	0	1,512,858	174,924	15,570
9.00	00900	HOUSEKEEPING	320	0	2,857,618	330,412	51,568
10.00	01000	DIETARY	103	0	1,069,212	123,628	75,100
11.00	01100	CAFETERIA	307	0	1,335,794	154,451	83,568
13.00	01300	NURSING ADMINISTRATION	0	0	1,988,539	229,925	60,981
14.00	01400	CENTRAL SERVICES & SUPPLY	2,237	0	651,476	75,327	59,665
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	975,405	112,781	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,475,297	170,581	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1,375,770	159,073	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	101,616	219,974	28,883,390	3,339,731	1,172,120
31.00	03100	INTENSIVE CARE UNIT	52,201	49,068	8,768,610	1,013,871	214,758
35.00	02060	NEONATAL INTENSIVE CARE UNIT	64	30,913	1,538,250	177,860	31,342
43.00	04300	NURSERY	7,862	8,699	173,544	20,066	15,418
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	282,170	768,124	19,354,242	2,237,834	542,284
50.01	05001	SAME DAY SURGERY	0	0	0	0	0
51.00	05100	RECOVERY ROOM	811	63,799	1,399,436	161,810	46,592
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,318	113,695	6,434,739	744,017	163,797
53.00	05300	ANESTHESIOLOGY	21,716	112,298	1,764,473	204,017	7,136
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,740	565,716	7,112,953	822,435	146,253
54.01	03480	ONCOLOGY	48	217,975	4,543,010	525,286	156,391
54.02	03440	MAMMOGRAPHY	802	41,170	2,253,969	260,615	0
56.00	05600	RADIOISOTOPE	805	105,767	1,983,766	229,373	30,195
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,030	150,573	2,152,049	248,831	36,083
59.00	05900	CARDIAC CATHETERIZATION	113,712	392,877	10,818,478	1,250,887	221,758
60.00	06000	LABORATORY	15,340	452,739	10,556,980	1,220,651	153,254
64.00	06400	INTRAVENOUS THERAPY	14,882	47,898	1,690,504	195,465	71,170
65.00	06500	RESPIRATORY THERAPY	12,422	64,854	2,416,456	279,403	26,720
66.00	06600	PHYSICAL THERAPY	1,783	95,792	4,812,723	556,471	26,383
69.00	06900	ELECTROCARDIOLOGY	2,951	302,233	10,193,821	1,178,661	37,044
70.00	07000	ELECTROENCEPHALOGRAPHY	2,029	4,924	320,795	37,092	9,362
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	280,631	10,752,860	1,243,299	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	240,883	14,501,714	1,676,761	0
73.00	07300	DRUGS CHARGED TO PATIENTS	17,633	502,135	27,663,285	3,198,567	41,481
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	595	8,204	1,932,542	223,450	0
91.00	09100	EMERGENCY	34,865	229,443	7,806,817	902,663	169,785
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	738,806	5,070,384	230,702,226	23,903,270	3,665,778
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	43,441	5,023	36,133
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	230,300	26,628	113,089
192.01	19201	FAMILY PRACTICE	0	0	0	0	0
192.02	19202	UNUSED SPACE	0	0	320,857	37,099	266,883
200.00		Cross Foot Adjustments			0		
201.00		Negative Cost Centers			0		0
202.00		TOTAL (sum lines 118 through 201)	738,806	5,070,384	231,296,824	23,972,020	4,081,883

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet B Part I Date/Time Prepared: 8/28/2018 9:29 am
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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	1,703,352				8.00
9.00	00900	HOUSEKEEPING	0	3,239,598			9.00
10.00	01000	DIETARY	0	60,600	1,328,540		10.00
11.00	01100	CAFETERIA	0	67,433	0	1,641,246	11.00
13.00	01300	NURSING ADMINISTRATION	0	49,207	0	14,256	2,342,908
14.00	01400	CENTRAL SERVICES & SUPPLY	0	48,145	0	19,602	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	28,512	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	33,858	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,335,022	945,814	1,041,258	424,125	943,639
31.00	03100	INTENSIVE CARE UNIT	299,229	173,293	233,386	110,486	247,301
35.00	02060	NEONATAL INTENSIVE CARE UNIT	69,101	25,291	53,896	19,602	42,804
43.00	04300	NURSERY	0	12,441	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	437,583	0	160,382	355,505
50.01	05001	SAME DAY SURGERY	0	0	0	0	0
51.00	05100	RECOVERY ROOM	0	37,596	0	14,256	32,125
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	132,172	0	106,922	237,648
53.00	05300	ANESTHESIOLOGY	0	5,758	0	16,038	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	118,015	0	71,281	0
54.01	03480	ONCOLOGY	0	126,196	0	24,948	0
54.02	03440	MAMMOGRAPHY	0	0	0	24,948	0
56.00	05600	RADIOISOTOPE	0	24,365	0	5,346	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	29,116	0	8,910	0
59.00	05900	CARDIAC CATHETERIZATION	0	178,942	0	90,883	200,388
60.00	06000	LABORATORY	0	123,664	0	89,101	0
64.00	06400	INTRAVENOUS THERAPY	0	57,429	0	26,730	0
65.00	06500	RESPIRATORY THERAPY	0	21,561	0	39,205	7,656
66.00	06600	PHYSICAL THERAPY	0	21,289	0	67,717	0
69.00	06900	ELECTROCARDIOLOGY	0	29,892	0	39,205	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,555	0	3,564	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	33,472	0	57,025	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	19,602	0
91.00	09100	EMERGENCY	0	137,004	0	124,742	275,842
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,703,352	2,903,833	1,328,540	1,641,246	2,342,908
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,157	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	91,254	0	0	0
192.01	19201	FAMILY PRACTICE	0	0	0	0	0
192.02	19202	UNUSED SPACE	0	215,354	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,703,352	3,239,598	1,328,540	1,641,246	2,342,908

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet B
Part I
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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	854,215				14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	1,116,698			16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,645,878		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		1,568,701	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,675	48,459	0	204,824	195,220 30.00
31.00 03100	INTENSIVE CARE UNIT	3,183	10,809	0	37,465	35,709 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	47	6,810	0	0	0 35.00
43.00 04300	NURSERY	2	1,916	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	324,001	168,929	0	73,370	69,929 50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	0 50.01
51.00 05100	RECOVERY ROOM	0	14,055	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,537	25,046	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	9,351	24,739	0	12,814	12,213 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	26,005	124,625	0	23,904	22,783 54.00
54.01 03480	ONCOLOGY	1,331	48,019	0	0	0 54.01
54.02 03440	MAMMOGRAPHY	420	9,070	0	0	0 54.02
56.00 05600	RADIOISOTOPE	8	23,300	0	0	0 56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	23	33,171	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	458,648	86,549	0	0	0 59.00
60.00 06000	LABORATORY	4,350	99,736	0	0	0 60.00
64.00 06400	INTRAVENOUS THERAPY	813	10,552	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	10,430	14,287	0	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0	21,103	0	22,375	21,326 66.00
69.00 06900	ELECTROCARDIOLOGY	4,499	66,581	0	5,204	4,960 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	978	1,085	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,190	61,822	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	53,065	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	110,618	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,118	1,807	0	224,142	213,632 88.00
91.00 09100	EMERGENCY	1,606	50,545	0	69,305	66,055 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 through 117)	854,215	1,116,698	0	673,403	641,827 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	FAMILY PRACTICE	0	0	0	972,475	926,874 192.01
192.02 19202	UNUSED SPACE	0	0	0	0	0 192.02
200.00	Cross Foot Adjustments			0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	854,215	1,116,698	0	1,645,878	1,568,701 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

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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	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				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,535,277	-400,044	38,135,233	30.00
31.00	03100	INTENSIVE CARE UNIT	11,148,100	-73,174	11,074,926	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,965,003	0	1,965,003	35.00
43.00	04300	NURSERY	223,387	0	223,387	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,724,059	-143,299	23,580,760	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	50.01
51.00	05100	RECOVERY ROOM	1,705,870	0	1,705,870	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,847,878	0	7,847,878	52.00
53.00	05300	ANESTHESIOLOGY	2,056,539	-25,027	2,031,512	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,468,254	-46,687	8,421,567	54.00
54.01	03480	ONCOLOGY	5,425,181	0	5,425,181	54.01
54.02	03440	MAMMOGRAPHY	2,549,022	0	2,549,022	54.02
56.00	05600	RADIOISOTOPE	2,296,353	0	2,296,353	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,508,183	0	2,508,183	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,306,533	0	13,306,533	59.00
60.00	06000	LABORATORY	12,247,736	0	12,247,736	60.00
64.00	06400	INTRAVENOUS THERAPY	2,052,663	0	2,052,663	64.00
65.00	06500	RESPIRATORY THERAPY	2,815,718	0	2,815,718	65.00
66.00	06600	PHYSICAL THERAPY	5,549,387	-43,701	5,505,686	66.00
69.00	06900	ELECTROCARDIOLOGY	11,559,867	-10,164	11,549,703	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	380,431	0	380,431	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,060,171	0	12,060,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,231,540	0	16,231,540	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,104,448	0	31,104,448	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,616,293	-437,774	2,178,519	88.00
91.00	09100	EMERGENCY	9,604,364	-135,360	9,469,004	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 through 117)	227,982,257	-1,315,230	226,667,027	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	113,754	0	113,754	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	461,271	0	461,271	192.00
192.01	19201	FAMILY PRACTICE	1,899,349	-1,899,349	0	192.01
192.02	19202	UNUSED SPACE	840,193	0	840,193	192.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	231,296,824	-3,214,579	228,082,245	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet Non-CMS W
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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	ASSIGNED TIME	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 04/01/2017
To 03/31/2018

Worksheet B
Part II
Date/Time Prepared:
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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	20,929	5,569	26,498	26,498 4.00
5.01 00550	DATA PROCESSING	0	36,829	0	36,829	0 5.01
5.02 00560	PURCHASING RECEIVING AND STORES	0	61,206	353	61,559	152 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	59,117	0	59,117	265 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	0	1,811,307	648,253	2,459,560	1,935 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	853,867	2,096	855,963	252 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	18,719	0	18,719	33 8.00
9.00 00900	HOUSEKEEPING	0	61,997	5,131	67,128	665 9.00
10.00 01000	DIETARY	0	90,289	34,226	124,515	150 10.00
11.00 01100	CAFETERIA	0	100,469	1,902	102,371	448 11.00
13.00 01300	NURSING ADMINISTRATION	0	73,314	658,264	731,578	327 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	71,732	1,731	73,463	137 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	7,122	7,122	227 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	438 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	1,409,166	455,441	1,864,607	5,549 30.00
31.00 03100	INTENSIVE CARE UNIT	0	258,190	276,637	534,827	1,771 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	37,681	144,763	182,444	324 35.00
43.00 04300	NURSERY	0	18,536	2,246	20,782	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	651,955	3,548,983	4,200,938	2,199 50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	0 50.01
51.00 05100	RECOVERY ROOM	0	56,015	67,303	123,318	277 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	196,923	149,728	346,651	1,429 52.00
53.00 05300	ANESTHESIOLOGY	0	8,579	54,198	62,777	275 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	175,831	1,202,080	1,377,911	1,040 54.00
54.01 03480	ONCOLOGY	0	188,020	1,526,547	1,714,567	336 54.01
54.02 03440	MAMMOGRAPHY	0	0	468,998	468,998	255 54.02
56.00 05600	RADIOISOTOPE	0	36,302	15,785	52,087	116 56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	43,380	1,352,876	1,396,256	123 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	266,607	2,200,148	2,466,755	1,441 59.00
60.00 06000	LABORATORY	0	184,248	604,569	788,817	898 60.00
64.00 06400	INTRAVENOUS THERAPY	0	85,563	59,895	145,458	308 64.00
65.00 06500	RESPIRATORY THERAPY	0	32,124	74,692	106,816	566 65.00
66.00 06600	PHYSICAL THERAPY	0	31,719	24,728	56,447	1,008 66.00
69.00 06900	ELECTROCARDIOLOGY	0	44,536	390,395	434,931	527 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	11,256	34,944	46,200	41 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	49,870	47,917	97,787	1,207 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	6,982	6,982	164 88.00
91.00 09100	EMERGENCY	0	204,123	403,490	607,613	1,615 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	7,250,399	14,477,992	21,728,391	26,498 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,441	0	43,441	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	135,960	0	135,960	0 192.00
192.01 19201	FAMILY PRACTICE	0	0	0	0	0 192.01
192.02 19202	UNUSED SPACE	0	320,857	0	320,857	0 192.02
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	7,750,657	14,477,992	22,228,649	26,498 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet B
Part II
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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	36,829					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	342	62,053				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	901	150	60,433			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,170	11	0	2,464,676		5.04
6.00	00600	MAINTENANCE & REPAIRS	622	0	0	43,496	900,333	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44	0	17,985	3,434	8.00
9.00	00900	HOUSEKEEPING	155	27	0	33,971	11,374	9.00
10.00	01000	DIETARY	435	9	0	12,711	16,565	10.00
11.00	01100	CAFETERIA	0	26	0	15,880	18,433	11.00
13.00	01300	NURSING ADMINISTRATION	373	0	0	23,640	13,450	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	155	188	0	7,745	13,160	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	839	0	0	11,596	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	17,538	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	16,355	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,902	8,535	2,601	343,366	258,530	30.00
31.00	03100	INTENSIVE CARE UNIT	1,616	4,384	580	104,241	47,369	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	249	5	365	18,287	6,913	35.00
43.00	04300	NURSERY	0	660	103	2,063	3,401	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,481	23,701	9,568	230,083	119,611	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	746	68	754	16,636	10,277	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,896	1,706	1,344	76,496	36,128	52.00
53.00	05300	ANESTHESIOLOGY	466	1,824	1,328	20,976	1,574	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	746	2,330	6,688	84,559	32,259	54.00
54.01	03480	ONCOLOGY	1,212	4	2,577	54,007	34,495	54.01
54.02	03440	MAMMOGRAPHY	963	67	487	26,795	0	54.02
56.00	05600	RADIOISOTOPE	186	68	1,250	23,583	6,660	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	93	87	1,780	25,584	7,959	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,989	9,551	4,645	128,610	48,913	59.00
60.00	06000	LABORATORY	1,399	1,288	5,353	125,501	33,803	60.00
64.00	06400	INTRAVENOUS THERAPY	559	1,250	566	20,097	15,698	64.00
65.00	06500	RESPIRATORY THERAPY	124	1,043	767	28,727	5,894	65.00
66.00	06600	PHYSICAL THERAPY	1,958	150	1,133	57,214	5,819	66.00
69.00	06900	ELECTROCARDIOLOGY	839	248	3,573	121,184	8,171	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	62	170	58	3,814	2,065	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,318	127,830	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,848	172,396	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	901	1,481	5,937	328,861	9,149	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,461	50	97	22,974	0	88.00
91.00	09100	EMERGENCY	1,989	2,928	2,713	92,807	37,449	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 through 117)	36,829	62,053	60,433	2,457,608	808,553	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	516	7,970	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,738	24,944	192.00
192.01	19201	FAMILY PRACTICE	0	0	0	0	0	192.01
192.02	19202	UNUSED SPACE	0	0	0	3,814	58,866	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 through 201)	36,829	62,053	60,433	2,464,676	900,333	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet B Part II Date/Time Prepared: 8/28/2018 9:29 am
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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	40,215				8.00
9.00	00900	HOUSEKEEPING	0	113,320			9.00
10.00	01000	DIETARY	0	2,120	156,505		10.00
11.00	01100	CAFETERIA	0	2,359	0	139,517	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,721	0	1,212	772,301
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,684	0	1,666	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,424	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	2,878	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31,519	33,086	122,663	36,055	311,054
31.00	03100	INTENSIVE CARE UNIT	7,065	6,062	27,493	9,392	81,519
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,631	885	6,349	1,666	14,110
43.00	04300	NURSERY	0	435	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	15,306	0	13,634	117,186
50.01	05001	SAME DAY SURGERY	0	0	0	0	0
51.00	05100	RECOVERY ROOM	0	1,315	0	1,212	10,589
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,623	0	9,089	78,337
53.00	05300	ANESTHESIOLOGY	0	201	0	1,363	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,128	0	6,059	0
54.01	03480	ONCOLOGY	0	4,414	0	2,121	0
54.02	03440	MAMMOGRAPHY	0	0	0	2,121	0
56.00	05600	RADIOISOTOPE	0	852	0	454	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,018	0	757	0
59.00	05900	CARDIAC CATHETERIZATION	0	6,259	0	7,726	66,055
60.00	06000	LABORATORY	0	4,326	0	7,574	0
64.00	06400	INTRAVENOUS THERAPY	0	2,009	0	2,272	0
65.00	06500	RESPIRATORY THERAPY	0	754	0	3,333	2,524
66.00	06600	PHYSICAL THERAPY	0	745	0	5,756	0
69.00	06900	ELECTROCARDIOLOGY	0	1,046	0	3,333	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	264	0	303	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	1,171	0	4,847	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,666	0
91.00	09100	EMERGENCY	0	4,792	0	10,604	90,927
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,215	101,575	156,505	139,517	772,301
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,020	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,192	0	0	0
192.01	19201	FAMILY PRACTICE	0	0	0	0	0
192.02	19202	UNUSED SPACE	0	7,533	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	40,215	113,320	156,505	139,517	772,301

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

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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	98,198				14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	22,208			16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		17,976	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			22.00
						19,233
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	193	954			30.00
31.00 03100	INTENSIVE CARE UNIT	366	213			31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	5	134			35.00
43.00 04300	NURSERY	0	38			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	37,247	3,556			50.00
50.01 05001	SAME DAY SURGERY	0	0			50.01
51.00 05100	RECOVERY ROOM	0	277			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	407	493			52.00
53.00 05300	ANESTHESIOLOGY	1,075	487			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,990	2,452			54.00
54.01 03480	ONCOLOGY	153	945			54.01
54.02 03440	MAMMOGRAPHY	48	178			54.02
56.00 05600	RADIOISOTOPE	1	458			56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	3	653			58.00
59.00 05900	CARDIAC CATHETERIZATION	52,723	1,703			59.00
60.00 06000	LABORATORY	500	1,963			60.00
64.00 06400	INTRAVENOUS THERAPY	93	208			64.00
65.00 06500	RESPIRATORY THERAPY	1,199	281			65.00
66.00 06600	PHYSICAL THERAPY	0	415			66.00
69.00 06900	ELECTROCARDIOLOGY	517	1,310			69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	112	21			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	252	1,217			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,044			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	2,177			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	129	36			88.00
91.00 09100	EMERGENCY	185	995			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 through 117)	98,198	22,208	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	17,976	19,233
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	98,198	22,208	0	17,976	19,233

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

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Part II
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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	3,025,614	0	3,025,614	30.00
31.00	03100	826,898	0	826,898	31.00
35.00	02060	233,367	0	233,367	35.00
43.00	04300	27,482	0	27,482	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	4,776,510	0	4,776,510	50.00
50.01	05001	0	0	0	50.01
51.00	05100	165,469	0	165,469	51.00
52.00	05200	558,599	0	558,599	52.00
53.00	05300	92,346	0	92,346	53.00
54.00	05400	1,521,162	0	1,521,162	54.00
54.01	03480	1,814,831	0	1,814,831	54.01
54.02	03440	499,912	0	499,912	54.02
56.00	05600	85,715	0	85,715	56.00
58.00	05800	1,434,313	0	1,434,313	58.00
59.00	05900	2,796,370	0	2,796,370	59.00
60.00	06000	971,422	0	971,422	60.00
64.00	06400	188,518	0	188,518	64.00
65.00	06500	152,028	0	152,028	65.00
66.00	06600	130,645	0	130,645	66.00
69.00	06900	575,679	0	575,679	69.00
70.00	07000	53,110	0	53,110	70.00
71.00	07100	132,617	0	132,617	71.00
72.00	07200	176,288	0	176,288	72.00
73.00	07300	453,518	0	453,518	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	33,559	0	33,559	88.00
91.00	09100	854,617	0	854,617	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		21,580,589	0	21,580,589	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	52,947	0	52,947	190.00
192.00	19200	166,834	0	166,834	192.00
192.01	19201	0	0	0	192.01
192.02	19202	391,070	0	391,070	192.02
200.00		37,209	0	37,209	200.00
201.00		0	0	0	201.00
202.00		22,228,649	0	22,228,649	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

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	382,174				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		7,336,737			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,032	2,822	67,334,957		4.00
5.01 00550	DATA PROCESSING	1,816	0	0	1,185	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	3,018	179	386,069	11	11,848,894 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,915	0	673,064	29	28,703 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	89,313	328,503	4,910,128	102	2,168 5.04
6.00 00600	MAINTENANCE & REPAIRS	42,103	1,062	640,377	20	1 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	923	0	83,593	0	8,319 8.00
9.00 00900	HOUSEKEEPING	3,057	2,600	1,688,447	5	5,125 9.00
10.00 01000	DIETARY	4,452	17,344	379,523	14	1,644 10.00
11.00 01100	CAFETERIA	4,954	964	1,137,081	0	4,925 11.00
13.00 01300	NURSING ADMINISTRATION	3,615	333,576	829,989	12	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,537	877	347,977	5	35,882 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	3,609	575,128	27	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	1,110,735	0	0 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	69,484	230,795	14,160,732	222	1,629,723 30.00
31.00 03100	INTENSIVE CARE UNIT	12,731	140,186	4,494,123	52	837,195 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,858	73,359	823,282	8	1,034 35.00
43.00 04300	NURSERY	914	1,138	0	0	126,096 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	32,147	1,798,452	5,582,382	112	4,525,371 50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	0 50.01
51.00 05100	RECOVERY ROOM	2,762	34,106	704,213	24	13,013 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,710	75,875	3,626,362	61	325,854 52.00
53.00 05300	ANESTHESIOLOGY	423	27,465	699,033	15	348,274 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,670	609,155	2,638,400	24	444,886 54.00
54.01 03480	ONCOLOGY	9,271	773,579	853,771	39	768 54.01
54.02 03440	MAMMOGRAPHY	0	237,665	646,159	31	12,867 54.02
56.00 05600	RADIOISOTOPE	1,790	7,999	295,364	6	12,917 56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	2,139	685,571	312,799	3	16,521 58.00
59.00 05900	CARDIAC CATHETERIZATION	13,146	1,114,927	3,658,373	64	1,823,717 59.00
60.00 06000	LABORATORY	9,085	306,366	2,279,370	45	246,018 60.00
64.00 06400	INTRAVENOUS THERAPY	4,219	30,352	782,435	18	238,671 64.00
65.00 06500	RESPIRATORY THERAPY	1,584	37,850	1,436,854	4	199,227 65.00
66.00 06600	PHYSICAL THERAPY	1,564	12,531	2,559,207	63	28,598 66.00
69.00 06900	ELECTROCARDIOLOGY	2,196	197,833	1,338,432	27	47,336 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	555	17,708	103,396	2	32,536 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	2,459	24,282	3,062,743	29	282,804 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	3,538	415,990	47	9,542 88.00
91.00 09100	EMERGENCY	10,065	204,469	4,099,426	64	559,159 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	357,507	7,336,737	67,334,957	1,185	11,848,894 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,142	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	6,704	0	0	0	0 192.00
192.01 19201	FAMILY PRACTICE	0	0	0	0	0 192.01
192.02 19202	UNUSED SPACE	15,821	0	0	0	0 192.02
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	7,750,657	14,477,992	22,100,497	9,690,223	738,806 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	20.280440	1.973356	0.328217	8,177.403376	0.062352 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			26,498	36,829	62,053 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000394	31.079325	0.005237 205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

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				
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)			4.00	5.01	5.02	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet B-1
Date/Time Prepared:
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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	998,998,776					5.03
5.04	00590	0	-23,972,020	207,324,804			5.04
6.00	00600	0	0	3,658,831	241,977		6.00
8.00	00800	0	0	1,512,858	923	35,595	8.00
9.00	00900	0	0	2,857,618	3,057	0	9.00
10.00	01000	0	0	1,069,212	4,452	0	10.00
11.00	01100	0	0	1,335,794	4,954	0	11.00
13.00	01300	0	0	1,988,539	3,615	0	13.00
14.00	01400	0	0	651,476	3,537	0	14.00
16.00	01600	0	0	975,405	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	1,475,297	0	0	21.00
22.00	02200	0	0	1,375,770	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	43,344,536	0	28,883,390	69,484	27,898	30.00
31.00	03100	9,668,476	0	8,768,610	12,731	6,253	31.00
35.00	02060	6,091,143	0	1,538,250	1,858	1,444	35.00
43.00	04300	1,714,181	0	173,544	914	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	151,262,644	0	19,354,242	32,147	0	50.00
50.01	05001	0	0	0	0	0	50.01
51.00	05100	12,571,329	0	1,399,436	2,762	0	51.00
52.00	05200	22,402,944	0	6,434,739	9,710	0	52.00
53.00	05300	22,127,741	0	1,764,473	423	0	53.00
54.00	05400	111,471,104	0	7,112,953	8,670	0	54.00
54.01	03480	42,950,833	0	4,543,010	9,271	0	54.01
54.02	03440	8,112,318	0	2,253,969	0	0	54.02
56.00	05600	20,840,825	0	1,983,766	1,790	0	56.00
58.00	05800	29,669,631	0	2,152,049	2,139	0	58.00
59.00	05900	77,414,224	0	10,818,478	13,146	0	59.00
60.00	06000	89,209,577	0	10,556,980	9,085	0	60.00
64.00	06400	9,437,957	0	1,690,504	4,219	0	64.00
65.00	06500	12,779,188	0	2,416,456	1,584	0	65.00
66.00	06600	18,875,269	0	4,812,723	1,564	0	66.00
69.00	06900	59,553,396	0	10,193,821	2,196	0	69.00
70.00	07000	970,211	0	320,795	555	0	70.00
71.00	07100	55,296,729	0	10,752,860	0	0	71.00
72.00	07200	47,464,656	0	14,501,714	0	0	72.00
73.00	07300	98,942,826	0	27,663,285	2,459	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,616,537	0	1,932,542	0	0	88.00
91.00	09100	45,210,501	0	7,806,817	10,065	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		998,998,776	-23,972,020	206,730,206	217,310	35,595	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	43,441	2,142	0	190.00
192.00	19200	0	0	230,300	6,704	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	320,857	15,821	0	192.02
200.00							200.00
201.00							201.00
202.00		5,070,384		23,972,020	4,081,883	1,703,352	202.00
203.00		0.005075		0.115625	16.868888	47.853687	203.00
204.00		60,433		2,464,676	900,333	40,215	204.00
205.00		0.000060		0.011888	3.720738	1.129794	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet B-1
Date/Time Prepared:
8/28/2018 9:29 am

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	237,997					9.00
10.00	01000	4,452	106,785				10.00
11.00	01100	4,954	0	921			11.00
13.00	01300	3,615	0	8	1,229,914		13.00
14.00	01400	3,537	0	11	0	10,471,383	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	69,484	83,694	238	495,365	20,529	30.00
31.00	03100	12,731	18,759	62	129,821	39,024	31.00
35.00	02060	1,858	4,332	11	22,470	575	35.00
43.00	04300	914	0	0	0	28	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	32,147	0	90	186,623	3,971,768	50.00
50.01	05001	0	0	0	0	0	50.01
51.00	05100	2,762	0	8	16,864	0	51.00
52.00	05200	9,710	0	60	124,754	43,355	52.00
53.00	05300	423	0	9	0	114,635	53.00
54.00	05400	8,670	0	40	0	318,785	54.00
54.01	03480	9,271	0	14	0	16,312	54.01
54.02	03440	0	0	14	0	5,150	54.02
56.00	05600	1,790	0	3	0	96	56.00
58.00	05800	2,139	0	5	0	288	58.00
59.00	05900	13,146	0	51	105,194	5,622,303	59.00
60.00	06000	9,085	0	50	0	53,330	60.00
64.00	06400	4,219	0	15	0	9,962	64.00
65.00	06500	1,584	0	22	4,019	127,853	65.00
66.00	06600	1,564	0	38	0	0	66.00
69.00	06900	2,196	0	22	0	55,152	69.00
70.00	07000	555	0	2	0	11,991	70.00
71.00	07100	0	0	0	0	26,851	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,459	0	32	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	11	0	13,706	88.00
91.00	09100	10,065	0	70	144,804	19,690	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		213,330	106,785	921	1,229,914	10,471,383	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,142	0	0	0	0	190.00
192.00	19200	6,704	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	15,821	0	0	0	0	192.02
200.00							200.00
201.00							201.00
202.00		3,239,598	1,328,540	1,641,246	2,342,908	854,215	202.00
203.00		13.611928	12.441260	1,782.026059	1.904936	0.081576	203.00
204.00		113,320	156,505	139,517	772,301	98,198	204.00
205.00		0.476140	1.465608	151.484256	0.627931	0.009378	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet B-1

Date/Time Prepared:
8/28/2018 9:29 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
			16.00	19.00		21.00
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	998,998,776				16.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	100			19.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0		50,608		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0			50,608	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	43,344,536	0	6,298	6,298	30.00	
31.00 03100 INTENSIVE CARE UNIT	9,668,476	0	1,152	1,152	31.00	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	6,091,143	0	0	0	35.00	
43.00 04300 NURSERY	1,714,181	0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	151,262,644	0	2,256	2,256	50.00	
50.01 05001 SAME DAY SURGERY	0	0	0	0	50.01	
51.00 05100 RECOVERY ROOM	12,571,329	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	22,402,944	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	22,127,741	100	394	394	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	111,471,104	0	735	735	54.00	
54.01 03480 ONCOLOGY	42,950,833	0	0	0	54.01	
54.02 03440 MAMMOGRAPHY	8,112,318	0	0	0	54.02	
56.00 05600 RADIOISOTOPE	20,840,825	0	0	0	56.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	29,669,631	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	77,414,224	0	0	0	59.00	
60.00 06000 LABORATORY	89,209,577	0	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	9,437,957	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	12,779,188	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	18,875,269	0	688	688	66.00	
69.00 06900 ELECTROCARDIOLOGY	59,553,396	0	160	160	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	970,211	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	55,296,729	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	47,464,656	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	98,942,826	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	1,616,537	0	6,892	6,892	88.00	
91.00 09100 EMERGENCY	45,210,501	0	2,131	2,131	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 through 117)	998,998,776	100	20,706	20,706	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	29,902	29,902	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)	1,116,698	0	1,645,878	1,568,701	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.001118	0.000000	32.522091	30.997095	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	22,208	0	17,976	19,233	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000022	0.000000	0.355201	0.380039	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
	16.00	19.00	21.00	22.00		
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet C
Part I
Date/Time Prepared:
8/28/2018 9:29 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	38,135,233		38,135,233	0	38,135,233	30.00
31.00	03100 INTENSIVE CARE UNIT	11,074,926		11,074,926	9,676	11,084,602	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1,965,003		1,965,003	0	1,965,003	35.00
43.00	04300 NURSERY	223,387		223,387	0	223,387	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	23,580,760		23,580,760	0	23,580,760	50.00
50.01	05001 SAME DAY SURGERY	0		0	0	0	50.01
51.00	05100 RECOVERY ROOM	1,705,870		1,705,870	0	1,705,870	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,847,878		7,847,878	12,214	7,860,092	52.00
53.00	05300 ANESTHESIOLOGY	2,031,512		2,031,512	0	2,031,512	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,421,567		8,421,567	0	8,421,567	54.00
54.01	03480 ONCOLOGY	5,425,181		5,425,181	56,748	5,481,929	54.01
54.02	03440 MAMMOGRAPHY	2,549,022		2,549,022	7,507	2,556,529	54.02
56.00	05600 RADIOISOTOPE	2,296,353		2,296,353	0	2,296,353	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,508,183		2,508,183	0	2,508,183	58.00
59.00	05900 CARDIAC CATHETERIZATION	13,306,533		13,306,533	82,671	13,389,204	59.00
60.00	06000 LABORATORY	12,247,736		12,247,736	0	12,247,736	60.00
64.00	06400 INTRAVENOUS THERAPY	2,052,663		2,052,663	11,014	2,063,677	64.00
65.00	06500 RESPIRATORY THERAPY	2,815,718	0	2,815,718	0	2,815,718	65.00
66.00	06600 PHYSICAL THERAPY	5,505,686	0	5,505,686	0	5,505,686	66.00
69.00	06900 ELECTROCARDIOLOGY	11,549,703		11,549,703	0	11,549,703	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	380,431		380,431	0	380,431	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,060,171		12,060,171	0	12,060,171	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16,231,540		16,231,540	0	16,231,540	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	31,104,448		31,104,448	0	31,104,448	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	2,178,519		2,178,519	0	2,178,519	88.00
91.00	09100 EMERGENCY	9,469,004		9,469,004	9,727	9,478,731	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,526,095		4,526,095		4,526,095	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	231,193,122	0	231,193,122	189,557	231,382,679	200.00
201.00	Less Observation Beds	4,526,095		4,526,095		4,526,095	201.00
202.00	Total (see instructions)	226,667,027	0	226,667,027	189,557	226,856,584	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet C
Part I
Date/Time Prepared:
8/28/2018 9:29 am

		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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,611,982		35,611,982			30.00
31.00	03100	INTENSIVE CARE UNIT	9,668,476		9,668,476			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,085,503		6,085,503			35.00
43.00	04300	NURSERY	1,714,181		1,714,181			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	88,016,018	61,517,983	149,534,001	0.157695	0.000000	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0.000000	0.000000	50.01
51.00	05100	RECOVERY ROOM	6,410,310	5,711,106	12,121,416	0.140732	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,320,020	4,982,596	22,302,616	0.351882	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	12,835,060	9,049,668	21,884,728	0.092828	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,123,303	76,738,679	109,861,982	0.076656	0.000000	54.00
54.01	03480	ONCOLOGY	408,247	42,407,727	42,815,974	0.126709	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	7,905,530	7,905,530	0.322435	0.000000	54.02
56.00	05600	RADIOISOTOPE	3,937,721	16,508,407	20,446,128	0.112312	0.000000	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,592,422	22,875,815	28,468,237	0.088105	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	27,895,444	49,202,716	77,098,160	0.172592	0.000000	59.00
60.00	06000	LABORATORY	42,004,616	44,861,852	86,866,468	0.140995	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	65,328	9,340,354	9,405,682	0.218236	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,477,844	1,284,740	12,762,584	0.220623	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,020,068	13,388,570	18,408,638	0.299082	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	15,684,705	43,130,888	58,815,593	0.196371	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	469,101	487,276	956,377	0.397784	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,242,559	24,260,580	54,503,139	0.221275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,289,082	18,032,028	47,321,110	0.343008	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,419,419	63,778,180	98,197,599	0.316754	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,616,537	1,616,537			88.00
91.00	09100	EMERGENCY	9,954,455	34,708,559	44,663,014	0.212010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,161,437	6,383,866	7,545,303	0.599856	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	428,407,301	558,173,657	986,580,958			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	428,407,301	558,173,657	986,580,958			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet C Part I Date/Time Prepared: 8/28/2018 9:29 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.157695		50.00
50.01	05001 SAME DAY SURGERY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.140732		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.352429		52.00
53.00	05300 ANESTHESIOLOGY	0.092828		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.076656		54.00
54.01	03480 ONCOLOGY	0.128035		54.01
54.02	03440 MAMMOGRAPHY	0.323385		54.02
56.00	05600 RADIOISOTOPE	0.112312		56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.088105		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.173664		59.00
60.00	06000 LABORATORY	0.140995		60.00
64.00	06400 INTRAVENOUS THERAPY	0.219407		64.00
65.00	06500 RESPIRATORY THERAPY	0.220623		65.00
66.00	06600 PHYSICAL THERAPY	0.299082		66.00
69.00	06900 ELECTROCARDIOLOGY	0.196371		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.397784		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.221275		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.343008		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.316754		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
91.00	09100 EMERGENCY	0.212228		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.599856		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 04/01/2017
To 03/31/2018

Worksheet C
Part I
Date/Time Prepared:
8/28/2018 9:29 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		38,135,233	0	38,135,233	30.00
31.00	03100 INTENSIVE CARE UNIT		11,074,926	9,676	11,084,602	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		1,965,003	0	1,965,003	35.00
43.00	04300 NURSERY		223,387	0	223,387	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		23,580,760	0	23,580,760	50.00
50.01	05001 SAME DAY SURGERY		0	0	0	50.01
51.00	05100 RECOVERY ROOM		1,705,870	0	1,705,870	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		7,847,878	12,214	7,860,092	52.00
53.00	05300 ANESTHESIOLOGY		2,031,512	0	2,031,512	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		8,421,567	0	8,421,567	54.00
54.01	03480 ONCOLOGY		5,425,181	56,748	5,481,929	54.01
54.02	03440 MAMMOGRAPHY		2,549,022	7,507	2,556,529	54.02
56.00	05600 RADIOISOTOPE		2,296,353	0	2,296,353	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		2,508,183	0	2,508,183	58.00
59.00	05900 CARDIAC CATHETERIZATION		13,306,533	82,671	13,389,204	59.00
60.00	06000 LABORATORY		12,247,736	0	12,247,736	60.00
64.00	06400 INTRAVENOUS THERAPY		2,052,663	11,014	2,063,677	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,815,718	0	2,815,718	65.00
66.00	06600 PHYSICAL THERAPY	0	5,505,686	0	5,505,686	66.00
69.00	06900 ELECTROCARDIOLOGY		11,549,703	0	11,549,703	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		380,431	0	380,431	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		12,060,171	0	12,060,171	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		16,231,540	0	16,231,540	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		31,104,448	0	31,104,448	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		2,178,519	0	2,178,519	88.00
91.00	09100 EMERGENCY		9,469,004	9,727	9,478,731	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		4,526,095	0	4,526,095	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		231,193,122	0	231,193,122	200.00
201.00	Less Observation Beds		4,526,095		4,526,095	201.00
202.00	Total (see instructions)		226,667,027	0	226,667,027	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0164		Period: From 04/01/2017 To 03/31/2018		Worksheet C Part I Date/Time Prepared: 8/28/2018 9:29 am	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,611,982		35,611,982			30.00
31.00	03100	INTENSIVE CARE UNIT	9,668,476		9,668,476			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,085,503		6,085,503			35.00
43.00	04300	NURSERY	1,714,181		1,714,181			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	88,016,018	61,517,983	149,534,001	0.157695	0.000000	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0.000000	0.000000	50.01
51.00	05100	RECOVERY ROOM	6,410,310	5,711,106	12,121,416	0.140732	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,320,020	4,982,596	22,302,616	0.351882	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	12,835,060	9,049,668	21,884,728	0.092828	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,123,303	76,738,679	109,861,982	0.076656	0.000000	54.00
54.01	03480	ONCOLOGY	408,247	42,407,727	42,815,974	0.126709	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	7,905,530	7,905,530	0.322435	0.000000	54.02
56.00	05600	RADIOISOTOPE	3,937,721	16,508,407	20,446,128	0.112312	0.000000	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,592,422	22,875,815	28,468,237	0.088105	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	27,895,444	49,202,716	77,098,160	0.172592	0.000000	59.00
60.00	06000	LABORATORY	42,004,616	44,861,852	86,866,468	0.140995	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	65,328	9,340,354	9,405,682	0.218236	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,477,844	1,284,740	12,762,584	0.220623	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,020,068	13,388,570	18,408,638	0.299082	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	15,684,705	43,130,888	58,815,593	0.196371	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	469,101	487,276	956,377	0.397784	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,242,559	24,260,580	54,503,139	0.221275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,289,082	18,032,028	47,321,110	0.343008	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,419,419	63,778,180	98,197,599	0.316754	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,616,537	1,616,537	1.347646	0.000000	88.00
91.00	09100	EMERGENCY	9,954,455	34,708,559	44,663,014	0.212010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,161,437	6,383,866	7,545,303	0.599856	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	428,407,301	558,173,657	986,580,958			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	428,407,301	558,173,657	986,580,958			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet C Part I Date/Time Prepared: 8/28/2018 9:29 am
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 04/01/2017 To 03/31/2018	Worksheet D Part I Date/Time Prepared: 8/28/2018 9:29 am
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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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,025,614	0	3,025,614	31,655	95.58	30.00
31.00	INTENSIVE CARE UNIT	826,898		826,898	6,253	132.24	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	233,367		233,367	1,444	161.61	35.00
43.00	NURSERY	27,482		27,482	2,568	10.70	43.00
200.00	Total (lines 30 through 199)	4,113,361		4,113,361	41,920		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	13,123	1,254,296				
31.00	INTENSIVE CARE UNIT	3,396	449,087				
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	16,519	1,703,383				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet D
Part II
Date/Time Prepared:
8/28/2018 9:29 am

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	4,776,510	149,534,001	0.031943	48,952,235	1,563,681	50.00
50.01	05001	SAME DAY SURGERY	0	0	0.000000	0	0	50.01
51.00	05100	RECOVERY ROOM	165,469	12,121,416	0.013651	2,525,414	34,474	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	558,599	22,302,616	0.025046	58,442	1,464	52.00
53.00	05300	ANESTHESIOLOGY	92,346	21,884,728	0.004220	5,095,316	21,502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,521,162	109,861,982	0.013846	14,966,033	207,220	54.00
54.01	03480	ONCOLOGY	1,814,831	42,815,974	0.042387	301,279	12,770	54.01
54.02	03440	MAMMOGRAPHY	499,912	7,905,530	0.063236	0	0	54.02
56.00	05600	RADIOISOTOPE	85,715	20,446,128	0.004192	2,308,835	9,679	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,434,313	28,468,237	0.050383	2,460,861	123,986	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,796,370	77,098,160	0.036270	5,383,037	195,243	59.00
60.00	06000	LABORATORY	971,422	86,866,468	0.011183	20,685,883	231,330	60.00
64.00	06400	INTRAVENOUS THERAPY	188,518	9,405,682	0.020043	51,887	1,040	64.00
65.00	06500	RESPIRATORY THERAPY	152,028	12,762,584	0.011912	6,170,670	73,505	65.00
66.00	06600	PHYSICAL THERAPY	130,645	18,408,638	0.007097	2,945,672	20,905	66.00
69.00	06900	ELECTROCARDIOLOGY	575,679	58,815,593	0.009788	7,511,499	73,523	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	53,110	956,377	0.055532	176,674	9,811	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	132,617	54,503,139	0.002433	14,132,699	34,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	176,288	47,321,110	0.003725	13,636,064	50,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	453,518	98,197,599	0.004618	18,604,320	85,915	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	33,559	1,616,537	0.020760	0	0	88.00
91.00	09100	EMERGENCY	854,617	44,663,014	0.019135	4,606,769	88,151	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	359,096	7,545,303	0.047592	651,974	31,029	92.00
200.00		Total (lines 50 through 199)	17,826,324	933,500,816		171,225,563	2,870,407	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part III Date/Time Prepared: 8/28/2018 9:29 am
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00	
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00	
30.00	03000	ADULTS & PEDIATRICS	0	0	31,655	0.00	13,123	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	6,253	0.00	3,396	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	1,444	0.00	0	35.00
43.00	04300	NURSERY	0	0	2,568	0.00	0	43.00
200.00		Total (lines 30 through 199)	0	0	41,920		16,519	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
INPATIENT ROUTINE SERVICE COST CENTERS			9.00	13.00				
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 through 199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part IV Date/Time Prepared: 8/28/2018 9:29 am
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Cost Center Description	Title XVIII			Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part IV Date/Time Prepared: 8/28/2018 9:29 am
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Cost Center Description		Title XVIII		Hospital		PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	149,534,001	0.000000	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	12,121,416	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	22,302,616	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	21,884,728	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	109,861,982	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	42,815,974	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	7,905,530	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	20,446,128	0.000000	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	28,468,237	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	77,098,160	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	86,866,468	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	9,405,682	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,762,584	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	18,408,638	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	58,815,593	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	956,377	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	54,503,139	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	47,321,110	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	98,197,599	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,616,537	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	44,663,014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,545,303	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	933,500,816		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet D
Part IV
Date/Time Prepared:
8/28/2018 9:29 am

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	48,952,235	0	33,080,538	0	50.00
50.01	05001 SAME DAY SURGERY	0.000000	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0.000000	2,525,414	0	3,797,795	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	58,442	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	5,095,316	0	2,549,942	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	14,966,033	0	21,350,851	0	54.00
54.01	03480 ONCOLOGY	0.000000	301,279	0	19,081,691	0	54.01
54.02	03440 MAMMOGRAPHY	0.000000	0	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0.000000	2,308,835	0	12,902,815	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,460,861	0	5,991,607	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	5,383,037	0	12,097,411	0	59.00
60.00	06000 LABORATORY	0.000000	20,685,883	0	10,307,063	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	51,887	0	3,984,366	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	6,170,670	0	531,269	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,945,672	0	108,362	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	7,511,499	0	7,986,949	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	176,674	0	110,387	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	14,132,699	0	9,411,970	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	13,636,064	0	9,665,389	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	18,604,320	0	28,259,849	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100 EMERGENCY	0.000000	4,606,769	0	7,109,701	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	651,974	0	2,232,573	0	92.00
200.00	Total (lines 50 through 199)		171,225,563	0	190,560,528	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part IV Date/Time Prepared: 8/28/2018 9:29 am
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Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS
		21.00	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 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part V Date/Time Prepared: 8/28/2018 9:29 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.157695	33,080,538	0	0	5,216,635	50.00
50.01	05001	SAME DAY SURGERY	0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.140732	3,797,795	0	0	534,471	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.351882	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.092828	2,549,942	0	0	236,706	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076656	21,350,851	0	0	1,636,671	54.00
54.01	03480	ONCOLOGY	0.126709	19,081,691	0	0	2,417,822	54.01
54.02	03440	MAMMOGRAPHY	0.322435	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.112312	12,902,815	0	0	1,449,141	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088105	5,991,607	0	0	527,891	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.172592	12,097,411	0	0	2,087,916	59.00
60.00	06000	LABORATORY	0.140995	10,307,063	15,911	0	1,453,244	60.00
64.00	06400	INTRAVENOUS THERAPY	0.218236	3,984,366	0	0	869,532	64.00
65.00	06500	RESPIRATORY THERAPY	0.220623	531,269	0	0	117,210	65.00
66.00	06600	PHYSICAL THERAPY	0.299082	108,362	0	0	32,409	66.00
69.00	06900	ELECTROCARDIOLOGY	0.196371	7,986,949	0	0	1,568,405	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.397784	110,387	0	0	43,910	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.221275	9,411,970	0	0	2,082,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.343008	9,665,389	0	0	3,315,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316754	28,259,849	0	39,640	8,951,420	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.212010	7,109,701	0	0	1,507,328	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.599856	2,232,573	0	0	1,339,222	92.00
200.00		Subtotal (see instructions)		190,560,528	15,911	39,640	35,387,873	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)		190,560,528	15,911	39,640	35,387,873	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part V Date/Time Prepared: 8/28/2018 9:29 am
	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	2,243	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	12,556	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)	2,243	12,556	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	2,243	12,556	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 8/28/2018 9:29 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		31,655	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		31,655	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)		27,898	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)		13,123	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)		38,135,233	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)		38,135,233	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)		38,135,233	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)		1,204.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,809,409	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)		15,809,409	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet D-1 Date/Time Prepared: 8/28/2018 9:29 am		
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	11,084,602	6,253	1,772.69	3,396	6,020,055	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	1,965,003	1,444	1,360.81	0	0	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					32,947,248	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					54,776,712	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)					1,703,383	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,870,407	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,573,790	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					50,202,922	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					3,757	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,204.71	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,526,095	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0164		Period: From 04/01/2017 To 03/31/2018		Worksheet D-1 Date/Time Prepared: 8/28/2018 9:29 am	
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	3,025,614	38,135,233	0.079339	4,526,095	359,096	90.00
91.00	Nursing School cost	0	38,135,233	0.000000	4,526,095	0	91.00
92.00	Allied health cost	0	38,135,233	0.000000	4,526,095	0	92.00
93.00	All other Medical Education	0	38,135,233	0.000000	4,526,095	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet D-3 Date/Time Prepared: 8/28/2018 9:29 am	
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		15,300,069	30.00
31.00	03100	INTENSIVE CARE UNIT		4,962,816	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	0.157695	48,952,235	50.00
50.01	05001	SAME DAY SURGERY	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0.140732	2,525,414	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.352429	58,442	52.00
53.00	05300	ANESTHESIOLOGY	0.092828	5,095,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076656	14,966,033	54.00
54.01	03480	ONCOLOGY	0.128035	301,279	54.01
54.02	03440	MAMMOGRAPHY	0.323385	0	54.02
56.00	05600	RADIOISOTOPE	0.112312	2,308,835	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088105	2,460,861	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.173664	5,383,037	59.00
60.00	06000	LABORATORY	0.140995	20,685,883	60.00
64.00	06400	INTRAVENOUS THERAPY	0.219407	51,887	64.00
65.00	06500	RESPIRATORY THERAPY	0.220623	6,170,670	65.00
66.00	06600	PHYSICAL THERAPY	0.299082	2,945,672	66.00
69.00	06900	ELECTROCARDIOLOGY	0.196371	7,511,499	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.397784	176,674	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.221275	14,132,699	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.343008	13,636,064	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316754	18,604,320	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.212228	4,606,769	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.599856	651,974	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		171,225,563	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)		171,225,563	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part A Date/Time Prepared: 8/28/2018 9:29 am
		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)		16,980,069	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		19,178,986	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)		1,683,480	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		4,636,306	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		155.11	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		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 § 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 § 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 § 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		15.66	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).		0.033331	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.032976	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.032976	21.00
22.00	IME payment adjustment (see instructions)		645,656	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		82,786	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		7.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		10.49	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)		0.045129	26.00
27.00	IME payments adjustment factor. (see instructions)		0.011905	27.00
28.00	IME add-on adjustment amount (see instructions)		430,474	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		55,195	28.01
29.00	Total IME payment (sum of lines 22 and 28)		1,076,130	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		137,981	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.97	30.00
31.00	Percentage of Medicaid patient days (see instructions)		26.13	31.00
32.00	Sum of lines 30 and 31		32.10	32.00
33.00	Allowable disproportionate share percentage (see instructions)		15.70	33.00
34.00	Disproportionate share adjustment (see instructions)		1,419,243	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part A Date/Time Prepared: 8/28/2018 9:29 am	
		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)		1,829,115	1,901,823	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		917,063	948,306	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,865,369		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)		42,203,277		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)		42,341,258		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,299,059		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).		398,458		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		15,503		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)		46,054,278		59.00
60.00	Primary payer payments		9,718		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		46,044,560		61.00
62.00	Deductibles billed to program beneficiaries		3,659,436		62.00
63.00	Coinurance billed to program beneficiaries		35,293		63.00
64.00	Allowable bad debts (see instructions)		1,478,680		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		961,142		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,148,497		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		43,310,973		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 Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				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)		210,258		70.93
70.94	HRR adjustment amount (see instructions)		-404,252		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part A Date/Time Prepared: 8/28/2018 9:29 am	
		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	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	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)			43,116,979	71.00
71.01	Sequestration adjustment (see instructions)			862,340	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			41,810,458	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, 71.02, 72, and 73)			444,181	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	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	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0164		Period: From 04/01/2017 To 03/31/2018		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)	5.97	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	26.13	0.00			26.13	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	32.10	0.00			26.13	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)	155.11	0.00			155.11	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	15.70	0.00			10.77	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)	5.97	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)	7,882	0			7,882	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1,381	0			1,381	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)	273	0			273	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	879	0			879	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	10,415	0			10,415	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	38,163	0			38,163	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	1,698	0			1,698	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)	39,861	0			39,861	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	26.13	0.00			26.13	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0164		Period: From 04/01/2017 To 03/31/2018		Worksheet DSH Date/Time Prepared: 8/28/2018 9:29 am	
		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	15.70		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		15.70		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.		15.70		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 04/01/2017 To 03/31/2018	Worksheet DSH Date/Time Prepared: 8/28/2018 9:29 am
		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	10.77	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	10.77	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.	10.77	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part B Date/Time Prepared: 8/28/2018 9:29 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		14,799	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		35,387,873	2.00
3.00	OPPS payments		31,720,662	3.00
4.00	Outlier payment (see instructions)		485,759	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.872	5.00
6.00	Line 2 times line 5		30,858,225	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		14,799	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		55,551	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)		55,551	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)		55,551	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		40,752	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		14,799	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		32,206,421	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)		5,874,956	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)		26,346,264	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		259,434	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)		26,605,698	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		26,605,698	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,502,036	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		976,323	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,124,790	36.00
37.00	Subtotal (see instructions)		27,582,021	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		27,582,021	40.00
40.01	Sequestration adjustment (see instructions)		551,640	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		26,539,955	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		490,426	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part B Date/Time Prepared: 8/28/2018 9:29 am
Title XVIII		Hospital	PPS
WORKSHEET OVERRIDE VALUES			Overrides
			1.00
112.00 Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet E-1
Part I
Date/Time Prepared:
8/28/2018 9:29 am

		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		41,810,458		26,539,955	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		41,810,458		26,539,955	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		444,181		490,426	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		42,254,639		27,030,381	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 04/01/2017
To 03/31/2018

Worksheet E-1
Part II
Date/Time Prepared:
8/28/2018 9:29 am

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		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00
			Overrides
			1.00
CONTRACTOR OVERRIDES			
108.00	Override of HIT payment		108.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet E-4 Date/Time Prepared: 8/28/2018 9:29 am	
		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)			15.66	6.00
7.00	Enter the lesser of line 5 or line 6			15.66	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.	15.66	0.00	15.66	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.	15.66	0.00	15.66	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	15.66	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).	15.75	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	15.75	0.00		17.00
18.00	Per resident amount	84,647.35	0.00		18.00
19.00	Approved amount for resident costs	1,333,196	0	1,333,196	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)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality 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)			1,333,196	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	16,519	2,194		26.00
27.00	Total Inpatient Days (see instructions)	37,293	37,293		27.00
28.00	Ratio of inpatient days to total inpatient days	0.442952	0.058831		28.00
29.00	Program direct GME amount	590,542	78,433		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		11,083		30.00
31.00	Net Program direct GME amount			657,892	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet E-4 Date/Time Prepared: 8/28/2018 9:29 am
		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)		54,776,712	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)		9,718	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		54,766,994	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		35,658,858	42.00
43.00	Primary payer payments (see instructions)		353	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		35,658,505	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		90,425,499	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.605659	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.394341	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		657,892	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		398,458	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		259,434	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 04/01/2017
To 03/31/2018

Worksheet G

Date/Time Prepared:
8/28/2018 9:29 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,960,768	0	8,804	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	195,894,985	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-137,065,439	0	0	0	6.00
7.00	Inventory	9,399,911	0	0	0	7.00
8.00	Prepaid expenses	1,142,576	0	0	0	8.00
9.00	Other current assets	699,044	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)	77,031,845	0	8,804	0	11.00
FIXED ASSETS						
12.00	Land	7,542,356	0	0	0	12.00
13.00	Land improvements	5,957,189	0	0	0	13.00
14.00	Accumulated depreciation	-3,509,582	0	0	0	14.00
15.00	Buildings	179,110,179	0	0	0	15.00
16.00	Accumulated depreciation	-84,286,826	0	0	0	16.00
17.00	Leasehold improvements	192,105	0	0	0	17.00
18.00	Accumulated depreciation	-156,094	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	634,975	0	0	0	21.00
22.00	Accumulated depreciation	-399,346	0	0	0	22.00
23.00	Major movable equipment	78,749,501	0	0	0	23.00
24.00	Accumulated depreciation	-49,716,443	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	7,714,140	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	141,832,154	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	12,144,554	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	263,466	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,408,020	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	231,272,019	0	8,804	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,676,451	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,606,598	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,123,340	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	14,207,535	0	0	0	43.00
44.00	Other current liabilities	3,152,975	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	36,766,899	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	155,773,460	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	121,754	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	155,895,214	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	192,662,113	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	38,609,906	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	8,804	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	38,609,906	0	8,804	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	231,272,019	0	8,804	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet G-1

Date/Time Prepared:
8/28/2018 9:29 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		64,141,529			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-25,531,623				2.00
3.00	Total (sum of line 1 and line 2)		38,609,906			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	GRANT TRANSACTIONS	0		0		718,832	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		38,609,906			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	GRANT TRANSACTIONS	0		0		710,028	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		38,609,906			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00	GRANT TRANSACTIONS		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	718,832		0			10.00
11.00	Subtotal (line 3 plus line 10)	718,832		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00	GRANT TRANSACTIONS		0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	710,028		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	8,804		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
8/28/2018 9:29 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	45,058,717		45,058,717	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)	45,058,717		45,058,717	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	9,668,476		9,668,476	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	6,091,143		6,091,143	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	15,759,619		15,759,619	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	60,818,336		60,818,336	17.00
18.00	Ancillary services	374,373,736	562,190,167	936,563,903	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,616,537	1,616,537	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)	435,192,072	563,806,704	998,998,776	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		231,784,120		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)		231,784,120		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0164

Period:
From 04/01/2017
To 03/31/2018

Worksheet G-3

Date/Time Prepared:
8/28/2018 9:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	998,998,776	1.00
2.00	Less contractual allowances and discounts on patients' accounts	705,731,710	2.00
3.00	Net patient revenues (line 1 minus line 2)	293,267,066	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	231,784,120	4.00
5.00	Net income from service to patients (line 3 minus line 4)	61,482,946	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	6,795,117	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	48,360	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	1,282,952	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	2,945	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	67,313	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	22,145	21.00
22.00	Rental of hospital space	875,306	22.00
23.00	Governmental appropriations	428,869	23.00
24.00	MISC., DEPARTMENTAL, MEANINGFUL USE	90,690	24.00
25.00	Total other income (sum of lines 6-24)	9,613,697	25.00
26.00	Total (line 5 plus line 25)	71,096,643	26.00
27.00	CORP. ALLOC, LOSS ON DEBT, LOSS EQUIP	96,628,266	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	96,628,266	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-25,531,623	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0164	Period: From 04/01/2017 To 03/31/2018	Worksheet L Parts I-III Date/Time Prepared: 8/28/2018 9:29 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,895,789	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		109,637	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)		102.17	3.00
4.00	Number of interns & residents (see instructions)		12.17	4.00
5.00	Indirect medical education percentage (see instructions)		3.42	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)		99,036	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		5.97	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		26.13	8.00
9.00	Sum of lines 7 and 8		32.10	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.72	10.00
11.00	Disproportionate share adjustment (see instructions)		194,597	11.00
12.00	Total prospective capital payments (see instructions)		3,299,059	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 04/01/2017

Worksheet M-1

Component CCN: 14-3454

To 03/31/2018

Date/Time Prepared: 8/28/2018 9:29 am

		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	151,062	0	151,062	0	151,062	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	3,454	0	3,454	0	3,454	9.00
10.00	Subtotal (sum of lines 1 through 9)	154,516	0	154,516	0	154,516	10.00
11.00	Physician Services Under Agreement	474,657	0	474,657	0	474,657	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	235,965	0	235,965	0	235,965	13.00
14.00	Subtotal (sum of lines 11 through 13)	710,622	0	710,622	0	710,622	14.00
15.00	Medical Supplies	0	104,213	104,213	-13,706	90,507	15.00
16.00	Transportation (Health Care Staff)	0	3,734	3,734	0	3,734	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	107,947	107,947	-13,706	94,241	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	865,138	107,947	973,085	-13,706	959,379	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	170,332	170,332	0	170,332	29.00
30.00	Administrative Costs	261,475	38,266	299,741	0	299,741	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	261,475	208,598	470,073	0	470,073	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,126,613	316,545	1,443,158	-13,706	1,429,452	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0164

Period: From 04/01/2017

Worksheet M-1

Component CCN: 14-3454

To 03/31/2018

Date/Time Prepared: 8/28/2018 9:29 am

		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	151,062		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	3,454		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	154,516		10.00
11.00	Physician Services Under Agreement	0	474,657		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	235,965		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	710,622		14.00
15.00	Medical Supplies	0	90,507		15.00
16.00	Transportation (Health Care Staff)	0	3,734		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	94,241		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	959,379		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				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	170,332		29.00
30.00	Administrative Costs	-33,564	266,177		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-33,564	436,509		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-33,564	1,395,888		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0164 Component CCN: 14-3454	Period: From 04/01/2017 To 03/31/2018	Worksheet M-2 Date/Time Prepared: 8/28/2018 9:29 am
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		RHC I		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		13,255		13,255	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)				959,379	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)				959,379	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)				436,509	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				782,631	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,219,140	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,219,140	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,219,140	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,178,519	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0164 Component CCN: 14-3454	Period: From 04/01/2017 To 03/31/2018	Worksheet M-3 Date/Time Prepared: 8/28/2018 9:29 am	
		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)			2,178,519	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			56,912	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,121,607	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)			13,255	5.00
6.00	Total adjusted visits (line 4 plus line 5)			13,255	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			160.06	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)		82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)		82.30	83.45	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		2,254	847	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		185,504	70,682	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	256,186	16.00
16.01	Total program charges (see instructions)(from contractor's records)			383,061	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			4,941	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			3,305	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.)			172,234	16.04
16.05	Total program cost (see instructions)		0	175,539	16.05
17.00	Primary payer amounts			353	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			37,588	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			69,086	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			175,186	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			27,109	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			202,295	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
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			202,295	26.00
26.01	Sequestration adjustment (see instructions)			4,046	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			169,363	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, 26.02, 27, and 28)			28,886	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 04/01/2017 To 03/31/2018	Worksheet M-4 Date/Time Prepared: 8/28/2018 9:29 am	
		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)		154,516	154,516	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.002425	0.011387	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		375	1,759	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		15,300	7,629	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		15,675	9,388	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		959,379	959,379	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,219,140	1,219,140	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.016339	0.009785	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		19,920	11,929	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		35,595	21,317	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		118	554	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		301.65	38.48	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		59	242	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		17,797	9,312	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)			56,912	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)			27,109	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 04/01/2017 To 03/31/2018	Worksheet M-5 Date/Time Prepared: 8/28/2018 9:29 am
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		169,363	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)		169,363	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		28,886	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		198,249	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00