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: 14-0011	Period: From 04/01/2016 To 03/31/2017	Worksheet S Parts I-III Date/Time Prepared: 8/15/2017 5:51 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/15/2017 Time: 5:51 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 HERRIN HOSPITAL (14-0011) for the cost reporting period beginning 04/01/2016 and ending 03/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-600,067	-103,898	300	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	68,764	175		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-531,303	-103,723	300	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 8/15/2017 5:50 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 S. 14TH STREET	PO Box:			1.00
2.00	City: HERRIN	State: IL	Zip Code: 62948	County:	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HERRIN HOSPITAL	140011	16060	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	HERRIN HOSPITAL ACUTE REHAB	14T011	16060	5	04/01/1998	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2016	03/31/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,937	217	0	0	59	209	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.	848	339	0	0	277		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 8/15/2017 5:50 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2	09/15/2014	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.	1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	04/01/2016	03/31/2017	38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 8/15/2017 5:50 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 8/15/2017 5:50 pm

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

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

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 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 Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.		N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	2,403,139	0	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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 8/15/2017 5:50 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H124	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 1239 E MAIN ST.	PO Box: 3988		142.00
143.00	City: CARBONDALE	State: IL	Zip Code: 62902	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0011	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/15/2017 5:50 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 8/15/2017 5:50 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	08/11/2017	Y	08/11/2017
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 8/15/2017 5:50 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN	41.00
42.00	Enter the employer/company name of the cost report preparer.	SO ILL HEALTHCARE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6184575200	LUANNE.WARREN@SIH.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0011	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part II Date/Time Prepared: 8/15/2017 5:50 pm

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

HFS Supplemental Information | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part IX Date/Time Prepared: 8/15/2017 5:50 pm

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
	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: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 8/15/2017 5:50 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,105	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)		77	28,105	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		85	31,025	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	29	10,585		0	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		114				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 8/15/2017 5:50 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	11,474	2,741	18,928			1.00
2.00	HMO and other (see instructions)	1,378	268				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	138	277				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	11,474	2,741	18,928			7.00
8.00	INTENSIVE CARE UNIT	1,289	413	2,158			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	12,763	3,154	21,086	0.00	743.01	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	4,756	1,187	7,358	0.00	58.48	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	801.49	27.00
28.00	Observation Bed Days		438	2,268			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 8/15/2017 5:50 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,315	1,078	6,231	1.00
2.00	HMO and other (see instructions)			345	93		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				14		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	3,315	1,078	6,231	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	278	67	425	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part II | Date/Time Prepared: 8/15/2017 5:50 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	44,260,609	0	44,260,609	1,667,105.70	26.55	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		382,469	0	382,469	6,756.00	56.61	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,288,648	-126,887	3,161,761	120,048.02	26.34	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		122,599	0	122,599	2,668.00	45.95	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		339,410	0	339,410	1,607.50	211.14	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		6,666,372	0	6,666,372	201,532.71	33.08	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,879,040	0	9,879,040			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		767,250	0	767,250			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		92,800	0	92,800			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		2,397,798	0	2,397,798			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	208,915	0	208,915	8,180.07	25.54	26.00
27.00	Administrative & General	5.00	4,294,338	0	4,294,338	137,979.87	31.12	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 8/15/2017 5:50 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,202,765	0	1,202,765	3,005.31	400.21	28.00
29.00	Maintenance & Repairs	6.00	522,425	0	522,425	23,508.39	22.22	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	38,757	0	38,757	2,966.60	13.06	31.00
32.00	Housekeeping	9.00	1,058,065	0	1,058,065	79,972.01	13.23	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,020,410	-649,795	370,615	24,505.57	15.12	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	649,795	649,795	42,965.32	15.12	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,044,141	0	1,044,141	31,363.33	33.29	38.00
39.00	Central Services and Supply	14.00	164,834	0	164,834	10,608.21	15.54	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	324,923	0	324,923	20,253.85	16.04	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: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 8/15/2017 5:50 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		45,080,905	0	45,080,905	1,663,355.01	27.10	1.00
2.00	Excluded area salaries (see instructions)		3,288,648	-126,887	3,161,761	120,048.02	26.34	2.00
3.00	Subtotal salaries (line 1 minus line 2)		41,792,257	126,887	41,919,144	1,543,306.99	27.16	3.00
4.00	Subtotal other wages & related costs (see inst.)		7,128,381	0	7,128,381	205,808.21	34.64	4.00
5.00	Subtotal wage-related costs (see inst.)		12,276,838	0	12,276,838	0.00	29.29	5.00
6.00	Total (sum of lines 3 thru 5)		61,197,476	126,887	61,324,363	1,749,115.20	35.06	6.00
7.00	Total overhead cost (see instructions)		9,879,573	0	9,879,573	385,308.53	25.64	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 8/15/2017 5:50 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	695,443	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	5,726	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)	4,315,157	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	84,797	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	39,258	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)	136,577	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	715,898	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	452,923	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,199,051	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	22,273	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))	113,000	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	98,937	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,879,040	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: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 8/15/2017 5:50 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	122,599	9,879,040	1.00
2.00	Hospital	122,599	9,879,040	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	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			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-10 | Date/Time Prepared: 8/15/2017 5:50 pm

		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)	0.205911	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,049,001	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,826,582	5.00
6.00	Medicaid charges	126,857,131	6.00
7.00	Medicaid cost (line 1 times line 6)	26,121,279	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	12,245,696	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	51,031	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	12,245,696	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	3,237,041	1,645,665	4,882,706	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	666,542	338,861	1,005,403	21.00
22.00	Partial payment by patients approved for charity care	2,681	19,794	22,475	22.00
23.00	Cost of charity care (line 21 minus line 22)	663,861	319,067	982,928	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	10,894,568	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	819,086	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	10,075,482	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,074,653	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,057,581	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,303,277	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,865,333	3,865,333	24,945	3,890,278	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,957,914	2,957,914	9,231	2,967,145	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	208,915	13,112,082	13,320,997	0	13,320,997	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	205,751	96,344	302,095	0	302,095	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	939,295	75,520	1,014,815	0	1,014,815	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,149,292	6,256,352	9,405,644	585	9,406,229	5.04
6.00	00600	MAINTENANCE & REPAIRS	522,425	1,063,975	1,586,400	-849	1,585,551	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,757	391,724	430,481	0	430,481	8.00
9.00	00900	HOUSEKEEPING	1,058,065	319,709	1,377,774	0	1,377,774	9.00
10.00	01000	DIETARY	1,020,410	782,725	1,803,135	-1,148,233	654,902	10.00
11.00	01100	CAFETERIA	0	0	0	1,148,233	1,148,233	11.00
13.00	01300	NURSING ADMINISTRATION	1,044,141	56,150	1,100,291	0	1,100,291	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	164,834	56,612	221,446	-733	220,713	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	324,923	37,386	362,309	0	362,309	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,442,500	1,442,500	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,328,255	6,888,218	15,216,473	-50,413	15,166,060	30.00
31.00	03100	INTENSIVE CARE UNIT	1,702,481	498,558	2,201,039	-12,392	2,188,647	31.00
41.00	04100	SUBPROVIDER - IRF	3,162,180	1,563,811	4,725,991	-1,900	4,724,091	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,848,909	6,597,310	10,446,219	-10,006,403	439,816	50.00
51.00	05100	RECOVERY ROOM	692,587	38,602	731,189	-1,280	729,909	51.00
53.00	05300	ANESTHESIOLOGY	412,823	1,752,433	2,165,256	-1,479,886	685,370	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,977,345	824,062	2,801,407	-37,187	2,764,220	54.00
56.00	05600	RADIOISOTOPE	228,540	1,350,108	1,578,648	-199,759	1,378,889	56.00
57.00	05700	CT SCAN	442,302	384,475	826,777	-53,184	773,593	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	287,049	143,335	430,384	-51,682	378,702	58.00
60.00	06000	LABORATORY	1,726,483	3,897,668	5,624,151	516,747	6,140,898	60.00
65.00	06500	RESPIRATORY THERAPY	1,007,373	263,064	1,270,437	-69,534	1,200,903	65.00
66.00	06600	PHYSICAL THERAPY	5,379,644	2,010,521	7,390,165	-45	7,390,120	66.00
69.00	06900	ELECTROCARDIOLOGY	711,480	421,897	1,133,377	-144,883	988,494	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,071,078	4,071,078	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,374,690	6,374,690	6,374,690	12,749,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,775,014	4,761,629	6,536,643	249,051	6,785,694	73.00
76.97	07697	CARDIAC REHABILITATION	418,203	17,160	435,363	0	435,363	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	178,729	509,853	688,582	-13,801	674,781	90.00
91.00	09100	EMERGENCY	3,177,936	3,804,571	6,982,507	-9,191	6,973,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,108,123	2,108,123	-34,176	2,073,947	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,134,141	73,281,914	117,416,055	521,529	117,937,584	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	117,995	117,995	0	117,995	192.00
192.01	19201	VACANT SPACE	-419	0	-419	0	-419	192.01
192.02	19202	REFERENCE LAB	126,887	394,642	521,529	-521,529	0	192.02
200.00		TOTAL (SUM OF LINES 118-199)	44,260,609	73,794,551	118,055,160	0	118,055,160	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-89,640	3,800,638		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,424,895	5,392,040		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,131,940	14,452,937		4.00
5.01	00550	DATA PROCESSING	4,746,247	4,746,247		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-5,419	296,676		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,372,815	3,387,630		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	4,984,604	14,390,833		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	1,585,551		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	430,481		8.00
9.00	00900	HOUSEKEEPING	0	1,377,774		9.00
10.00	01000	DIETARY	0	654,902		10.00
11.00	01100	CAFETERIA	-532,281	615,952		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,100,291		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	220,713		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-74,197	288,112		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,442,500	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-4,225,182	10,940,878		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,188,647		31.00
41.00	04100	SUBPROVIDER - IRF	-1,203,852	3,520,239		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-499,813	-59,997		50.00
51.00	05100	RECOVERY ROOM	0	729,909		51.00
53.00	05300	ANESTHESIOLOGY	0	685,370		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-81,846	2,682,374		54.00
56.00	05600	RADIOISOTOPE	0	1,378,889		56.00
57.00	05700	CT SCAN	0	773,593		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	378,702		58.00
60.00	06000	LABORATORY	-159,018	5,981,880		60.00
65.00	06500	RESPIRATORY THERAPY	-10,874	1,190,029		65.00
66.00	06600	PHYSICAL THERAPY	-263,964	7,126,156		66.00
69.00	06900	ELECTROCARDIOLOGY	-161,516	826,978		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,071,078		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,749,380		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,785,694		73.00
76.97	07697	CARDIAC REHABILITATION	-521	434,842		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-48,626	626,155		90.00
91.00	09100	EMERGENCY	-2,732,677	4,240,639		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-2,073,947	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,054,628	119,992,212		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-44,322	73,673		192.00
192.01	19201	VACANT SPACE	0	-419		192.01
192.02	19202	REFERENCE LAB	0	0		192.02
200.00		TOTAL (SUM OF LINES 118-199)	2,010,306	120,065,466		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet Non-CMS W | Date/Time Prepared: 8/15/2017 5:50 pm

	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
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
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
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	VACANT SPACE	19201		192.01
192.02	REFERENCE LAB	19202		192.02
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-6 | Date/Time Prepared: 8/15/2017 5:50 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	649,795	498,438	1.00
	TOTALS		649,795	498,438	
	B - MEDICAL SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,445,768	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	10,445,768	
	C - CRNA RECLASS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,442,500	1.00
	TOTALS		0	1,442,500	
	D - INTEREST RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	24,945	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,231	2.00
	TOTALS		0	34,176	
	E - IMPLANTABLE SUPPLY RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,374,690	1.00
	TOTALS		0	6,374,690	
	G - CONTRAST DRUG RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	249,245	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
	TOTALS		0	249,245	
	H - REFERENCE LAB RECLASS				
1.00	LABORATORY	60.00	126,887	394,642	1.00
	TOTALS		126,887	394,642	
	I - ENDOSCOPY MED DIRECTOR RECLASS				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,040	1.00
	TOTALS		0	1,040	
500.00	Grand Total: Increases		776,682	19,440,499	500.00

RECLASSIFICATIONS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-6 | Date/Time Prepared: 8/15/2017 5:50 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	649,795	498,438	0		1.00
	TOTALS		649,795	498,438			
	B - MEDICAL SUPPLY RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	455	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	50,413	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	1,900	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	12,392	0		4.00
5.00	OPERATING ROOM	50.00	0	10,005,363	0		5.00
6.00	RECOVERY ROOM	51.00	0	1,280	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	733	0		7.00
8.00	EMERGENCY	91.00	0	9,191	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	37,386	0		9.00
10.00	MAINTENANCE & REPAIRS	6.00	0	849	0		10.00
11.00	RADIOISOTOPE	56.00	0	199,759	0		11.00
12.00	CT SCAN	57.00	0	3,784	0		12.00
13.00	LABORATORY	60.00	0	4,782	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	69,534	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	45	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	33,907	0		16.00
17.00	CLINIC	90.00	0	13,801	0		17.00
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	194	0		18.00
	TOTALS		0	10,445,768			
	C - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	1,442,500	0		1.00
	TOTALS		0	1,442,500			
	D - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	34,176	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	34,176			
	E - IMPLANTABLE SUPPLY RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,374,690	0		1.00
	TOTALS		0	6,374,690			
	G - CONTRAST DRUG RECLASS						
1.00	ELECTROCARDIOLOGY	69.00	0	110,976	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37,187	0		2.00
3.00	CT SCAN	57.00	0	49,400	0		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	51,682	0		4.00
	TOTALS		0	249,245			
	H - REFERENCE LAB RECLASS						
1.00	REFERENCE LAB	192.02	126,887	394,642	0		1.00
	TOTALS		126,887	394,642			
	I - ENDOSCOPY MED DIRECTOR RECLASS						
1.00	OPERATING ROOM	50.00	0	1,040	0		1.00
	TOTALS		0	1,040			
500.00	Grand Total: Decreases		776,682	19,440,499			500.00

RECLASSIFICATIONS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 8/15/2017 5:50 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - CAFETERIA RECLASS								
1.00	CAFETERIA	11.00	649,795	498,438	DIETARY	10.00	649,795	498,438	1.00
	TOTALS		649,795	498,438	TOTALS		649,795	498,438	
	B - MEDICAL SUPPLY RECLASS								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,445,768	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	455	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	50,413	2.00
3.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	1,900	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	12,392	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	10,005,363	5.00
6.00		0.00	0	0	RECOVERY ROOM	51.00	0	1,280	6.00
7.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	733	7.00
8.00		0.00	0	0	EMERGENCY	91.00	0	9,191	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	37,386	9.00
10.00		0.00	0	0	MAINTENANCE & REPAIRS	6.00	0	849	10.00
11.00		0.00	0	0	RADIOISOTOPE	56.00	0	199,759	11.00
12.00		0.00	0	0	CT SCAN	57.00	0	3,784	12.00
13.00		0.00	0	0	LABORATORY	60.00	0	4,782	13.00
14.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	69,534	14.00
15.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	45	15.00
16.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	33,907	16.00
17.00		0.00	0	0	CLINIC	90.00	0	13,801	17.00
18.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	194	18.00
	TOTALS		0	10,445,768	TOTALS		0	10,445,768	
	C - CRNA RECLASS								
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,442,500	ANESTHESIOLOGY	53.00	0	1,442,500	1.00
	TOTALS		0	1,442,500	TOTALS		0	1,442,500	
	D - INTEREST RECLASS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	24,945	INTEREST EXPENSE	113.00	0	34,176	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,231		0.00	0	0	2.00
	TOTALS		0	34,176	TOTALS		0	34,176	
	E - IMPLANTABLE SUPPLY RECLASS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,374,690	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,374,690	1.00
	TOTALS		0	6,374,690	TOTALS		0	6,374,690	
	G - CONTRAST DRUG RECLASS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	249,245	ELECTROCARDIOLOGY	69.00	0	110,976	1.00
2.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	37,187	2.00
3.00		0.00	0	0	CT SCAN	57.00	0	49,400	3.00
4.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	51,682	4.00
	TOTALS		0	249,245	TOTALS		0	249,245	
	H - REFERENCE LAB RECLASS								
1.00	LABORATORY	60.00	126,887	394,642	REFERENCE LAB	192.02	126,887	394,642	1.00
	TOTALS		126,887	394,642	TOTALS		126,887	394,642	
	I - ENDOSCOPY MED DIRECTOR RECLASS								
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,040	OPERATING ROOM	50.00	0	1,040	1.00
	TOTALS		0	1,040	TOTALS		0	1,040	
500.00	Grand Total: Increases		776,682	19,440,499	Grand Total: Decreases		776,682	19,440,499	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 8/15/2017 5:50 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,897,097	222,275	0	222,275	0	1.00
2.00	Land Improvements	4,448,271	216,048	0	216,048	83,393	2.00
3.00	Buildings and Fixtures	70,347,486	12,836,624	0	12,836,624	3,088,023	3.00
4.00	Building Improvements	12,953	13,850	0	13,850	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	29,167,196	5,257,370	0	5,257,370	1,550,890	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	107,873,003	18,546,167	0	18,546,167	4,722,306	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	107,873,003	18,546,167	0	18,546,167	4,722,306	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,119,372	0	1.00
2.00	Land Improvements	4,580,926	0	2.00
3.00	Buildings and Fixtures	80,096,087	0	3.00
4.00	Building Improvements	26,803	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	32,873,676	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	121,696,864	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	121,696,864	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 8/15/2017 5:50 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,865,333	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,957,914	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,823,247	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	3,865,333		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,957,914		2.00
3.00	Total (sum of lines 1-2)	0	6,823,247		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 8/15/2017 5:50 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	88,823,186	0	88,823,186	0.729872	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,873,676	0	32,873,676	0.270128	0	2.00
3.00	Total (sum of lines 1-2)	121,696,862	0	121,696,862	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,800,638	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,392,040	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,192,678	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	3,800,638	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,392,040	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	9,192,678	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8 | Date/Time Prepared: 8/15/2017 5:50 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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	-9,098,618			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	21,039,779			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-532,281	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	-74,197	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-1,442,500	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
33.00	TELEVISION AND RADIO SERVICES	A	-1,644	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8 | Date/Time Prepared: 8/15/2017 5:50 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	INTEREST INCOME UNRESTRICTED	B	-570,751	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01
33.02	PAYMENTS FOR OUTPATIENT SERVICES	B	-2,254,085	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	NONALLOWABLE BOND EXPENSE	A	-2,073,947	INTEREST EXPENSE	113.00	0	33.03
33.04	PURCHASE DISCOUNTS	B	-5,419	PURCHASING RECEIVING AND STORES	5.02	0	33.04
33.05	CABLE TV	A	-1,020	SUBPROVIDER - IRF	41.00	0	33.05
33.06	OFFSET OF LOBBYING EXPENSES	A	-21,312	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.06
33.07	COMMUNITY DONATIONS	A	-11,958	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.07
33.08	LEASEHOLD REVENUE	B	-314,739	CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09	DEBT FORGIVENESS	A	-120,726	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
33.10	FUNDED DEPRECIATION	A	-1,126	CAP REL COSTS-BLDG & FIXT	1.00	9	33.10
33.11	REAL ESTATE TAXES	A	-34,345	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12	MEDICAID PROVIDER TAX	A	-2,659,925	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13	CABLE TV	A	-608	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
33.14	XRAY FILM/SILVER REVENUE	B	-1,339	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15	LOSS ON 1991 BONDS	A	97,444	CAP REL COSTS-BLDG & FIXT	1.00	9	33.15
33.16	LOSS ON 1991 BONDS	A	133,685	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
33.17	MISCELLANEOUS INCOME	B	-28	LABORATORY	60.00	0	33.17
33.18	REAL ESTATE TAXES	A	-9,166	PHYSICAL THERAPY	66.00	0	33.18
33.19	DR. TIBREWALA OVERPAYMENT PRIOR YEAR	A	1,040	OPERATING ROOM	50.00	0	33.19
33.20	DR. QURESHI OVERPAYMENT PRIOR YEAR	A	1,380	EMERGENCY	91.00	0	33.20
33.21	CABLE TV	A	-606	PHYSICAL THERAPY	66.00	0	33.21
33.22	ADD DR. HATCHETT MED DIR FROM MHC	A	11,640	OPERATING ROOM	50.00	0	33.22
33.23	REAL ESTATE TAXES	A	-44,322	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,010,306				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: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 8/15/2017 5:50 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	128,781	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,292,854	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,386,025	0	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	4,746,247	0	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	2,372,815	0	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	8,404,229	0	4.02
4.03	90.00	CLINIC	RENT	12,349	16,674	4.03
4.04	60.00	LABORATORY	RENT	35,265	82,215	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	RENT	54,817	135,324	4.05
4.06	66.00	PHYSICAL THERAPY	RENT	86,711	223,159	4.06
4.07	41.00	SUBPROVIDER - IRF	RENT	10,967	24,719	4.07
4.08	69.00	ELECTROCARDIOLOGY	RENT	5,174	14,364	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			21,536,234	496,455	5.00

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

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

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

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

6.00	B	SIHS	100.00	SIHS	100.00	6.00
7.00	B	SIHE	100.00	SIHE	100.00	7.00
8.00	B	HSSI	100.00	HSSI	100.00	8.00
9.00	B	SIMS	100.00	SIMS	100.00	9.00
10.00	B	SIH CAYMAN	100.00	SIH CAYMAN	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 8/15/2017 5:50 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	128,781	9		1.00
2.00	2,292,854	9		2.00
3.00	3,386,025	0		3.00
4.00	4,746,247	0		4.00
4.01	2,372,815	0		4.01
4.02	8,404,229	0		4.02
4.03	-4,325	0		4.03
4.04	-46,950	0		4.04
4.05	-80,507	0		4.05
4.06	-136,448	0		4.06
4.07	-13,752	0		4.07
4.08	-9,190	0		4.08
5.00	21,039,779			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: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 8/15/2017 5:50 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	DR. A	210,278	0	210,278	260,300	785	1.00
2.00	65.00	DR. B	32,905	0	32,905	179,000	256	2.00
3.00	69.00	DR. C	154,994	151,556	3,438	179,000	31	3.00
4.00	76.97	DR. D	1,898	110	1,788	179,000	16	4.00
5.00	91.00	DR. E	2,745,737	2,727,279	18,458	181,300	134	5.00
6.00	30.00	DR. F	4,225,182	4,225,182	0	0	0	6.00
7.00	41.00	DR. G	1,189,080	1,189,080	0	0	0	7.00
8.00	50.00	DR. H	558,219	485,676	72,543	246,400	386	8.00
9.00	90.00	DR. I	44,301	44,301	0	0	0	9.00
10.00	66.00	DR. J	117,744	117,744	0	0	0	10.00
200.00			9,280,338	8,940,928	339,410		1,608	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	60.00	DR. A	98,238	4,912	0	0	0	1.00
2.00	65.00	DR. B	22,031	1,102	0	0	0	2.00
3.00	69.00	DR. C	2,668	133	0	0	0	3.00
4.00	76.97	DR. D	1,377	69	0	0	0	4.00
5.00	91.00	DR. E	11,680	584	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	41.00	DR. G	0	0	0	0	0	7.00
8.00	50.00	DR. H	45,726	2,286	0	0	0	8.00
9.00	90.00	DR. I	0	0	0	0	0	9.00
10.00	66.00	DR. J	0	0	0	0	0	10.00
200.00			181,720	9,086	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	60.00	DR. A	0	98,238	112,040	112,040		1.00
2.00	65.00	DR. B	0	22,031	10,874	10,874		2.00
3.00	69.00	DR. C	0	2,668	770	152,326		3.00
4.00	76.97	DR. D	0	1,377	411	521		4.00
5.00	91.00	DR. E	0	11,680	6,778	2,734,057		5.00
6.00	30.00	DR. F	0	0	0	4,225,182		6.00
7.00	41.00	DR. G	0	0	0	1,189,080		7.00
8.00	50.00	DR. H	0	45,726	26,817	512,493		8.00
9.00	90.00	DR. I	0	0	0	44,301		9.00
10.00	66.00	DR. J	0	0	0	117,744		10.00
200.00			0	181,720	157,690	9,098,618		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,800,638	3,800,638				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,392,040		5,392,040			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,452,937	27,213	4,588	14,484,738		4.00
5.01	00550	DATA PROCESSING	4,746,247	17,583	0	0	4,763,830	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	296,676	31,418	1,560	67,653	37,560	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,387,630	25,840	6,923	308,849	187,799	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	14,390,833	694,229	99,413	1,035,516	388,118	5.04
6.00	00600	MAINTENANCE & REPAIRS	1,585,551	466,420	11,659	171,778	118,939	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	430,481	0	576	12,744	0	8.00
9.00	00900	HOUSEKEEPING	1,377,774	51,442	19,163	347,901	12,520	9.00
10.00	01000	DIETARY	654,902	57,868	31,597	121,862	50,080	10.00
11.00	01100	CAFETERIA	615,952	70,279	0	213,658	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,100,291	16,328	309,435	343,323	50,080	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	220,713	39,370	713	54,199	6,260	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	288,112	0	16,138	106,838	131,459	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,940,878	644,720	273,954	2,738,410	888,912	30.00
31.00	03100	INTENSIVE CARE UNIT	2,188,647	74,874	116,749	559,791	93,899	31.00
41.00	04100	SUBPROVIDER - IRF	3,520,239	301,616	92,593	1,039,753	444,457	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	-59,997	505,552	1,706,317	1,265,556	219,099	50.00
51.00	05100	RECOVERY ROOM	729,909	28,383	194,002	227,729	25,040	51.00
53.00	05300	ANESTHESIOLOGY	685,370	475	57,285	135,740	31,300	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,682,374	115,770	749,417	650,169	212,839	54.00
56.00	05600	RADIOISOTOPE	1,378,889	26,094	160,169	75,146	31,300	56.00
57.00	05700	CT SCAN	773,593	17,294	219,233	145,433	12,520	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	378,702	12,394	287,478	94,384	6,260	58.00
60.00	06000	LABORATORY	5,981,880	98,204	429,622	609,405	256,658	60.00
65.00	06500	RESPIRATORY THERAPY	1,190,029	53,511	103,215	331,233	169,019	65.00
66.00	06600	PHYSICAL THERAPY	7,126,156	122,162	74,512	1,768,875	807,535	66.00
69.00	06900	ELECTROCARDIOLOGY	826,978	44,083	144,494	233,941	181,539	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,071,078	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,749,380	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,785,694	34,114	71,435	583,641	106,419	73.00
76.97	07697	CARDIAC REHABILITATION	434,842	31,842	13,346	137,509	62,600	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	626,155	0	319	58,768	12,520	90.00
91.00	09100	EMERGENCY	4,240,639	164,330	193,018	1,044,934	212,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	119,992,212	3,773,408	5,388,923	14,484,738	4,757,570	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,734	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	73,673	10,343	3,117	0	6,260	192.00
192.01	19201	VACANT SPACE	-419	2,153	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	120,065,466	3,800,638	5,392,040	14,484,738	4,763,830	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	434,867					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,014	3,919,055				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	16,608,109	16,608,109		5.04
6.00	00600	MAINTENANCE & REPAIRS	8	0	2,354,355	377,947	2,732,302	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	443,801	71,244	0	8.00
9.00	00900	HOUSEKEEPING	30	0	1,808,830	290,373	55,382	9.00
10.00	01000	DIETARY	30	0	916,339	147,101	62,300	10.00
11.00	01100	CAFETERIA	52	0	899,941	144,468	75,661	11.00
13.00	01300	NURSING ADMINISTRATION	56	0	1,819,513	292,088	17,578	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	879	0	322,134	51,712	42,385	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	542,547	87,096	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	88,773	151,846	15,727,493	2,524,749	694,097	30.00
31.00	03100	INTENSIVE CARE UNIT	25,464	19,552	3,078,976	494,271	80,608	31.00
41.00	04100	SUBPROVIDER - IRF	13,715	90,022	5,502,395	883,305	324,715	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	203,944	512,804	4,353,275	698,836	544,270	50.00
51.00	05100	RECOVERY ROOM	2,243	42,218	1,249,524	200,587	30,557	51.00
53.00	05300	ANESTHESIOLOGY	9,515	78,505	998,190	160,240	511	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	249,264	4,659,833	748,048	124,636	54.00
56.00	05600	RADIOISOTOPE	1,102	164,778	1,837,478	294,972	28,092	56.00
57.00	05700	CT SCAN	9,922	530,556	1,708,551	274,275	18,619	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	590	134,306	914,114	146,744	13,343	58.00
60.00	06000	LABORATORY	13,694	619,315	8,008,778	1,285,657	105,725	60.00
65.00	06500	RESPIRATORY THERAPY	7,502	53,860	1,908,369	306,352	57,609	65.00
66.00	06600	PHYSICAL THERAPY	2,684	275,121	10,177,045	1,633,731	131,518	66.00
69.00	06900	ELECTROCARDIOLOGY	1,885	172,635	1,605,555	257,741	47,460	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	150,556	4,221,634	677,703	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	120,861	12,870,241	2,066,073	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	934	249,196	7,831,433	1,257,188	36,726	73.00
76.97	07697	CARDIAC REHABILITATION	154	13,008	693,301	111,296	34,280	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,507	22,943	723,212	116,098	0	90.00
91.00	09100	EMERGENCY	47,170	267,709	6,170,639	990,579	176,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	434,867	3,919,055	119,955,605	16,590,474	2,702,987	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	14,734	2,365	15,862	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	93,393	14,992	11,135	192.00
192.01	19201	VACANT SPACE	0	0	1,734	278	2,318	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	434,867	3,919,055	120,065,466	16,608,109	2,732,302	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	515,045					8.00
9.00	00900	HOUSEKEEPING	0	2,154,585				9.00
10.00	01000	DIETARY	0	50,144	1,175,884			10.00
11.00	01100	CAFETERIA	0	60,898	0	1,180,968		11.00
13.00	01300	NURSING ADMINISTRATION	0	14,148	0	33,220	2,176,547	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,115	0	5,244	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	10,338	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	342,735	558,660	782,490	264,991	978,247	30.00
31.00	03100	INTENSIVE CARE UNIT	39,076	64,880	89,212	54,166	479,737	31.00
41.00	04100	SUBPROVIDER - IRF	133,234	261,355	304,182	100,608	200,238	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	438,069	0	122,457	34,416	50.00
51.00	05100	RECOVERY ROOM	0	24,594	0	22,035	3,129	51.00
53.00	05300	ANESTHESIOLOGY	0	411	0	13,134	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100,316	0	62,911	0	54.00
56.00	05600	RADIOISOTOPE	0	22,611	0	7,271	0	56.00
57.00	05700	CT SCAN	0	14,986	0	14,072	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,740	0	9,133	0	58.00
60.00	06000	LABORATORY	0	85,096	0	58,967	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	46,368	0	32,051	0	65.00
66.00	06600	PHYSICAL THERAPY	0	105,855	0	171,159	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	38,199	0	22,636	0	69.00
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	29,560	0	56,474	3,129	73.00
76.97	07697	CARDIAC REHABILITATION	0	27,591	0	13,306	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,686	0	90.00
91.00	09100	EMERGENCY	0	142,394	0	101,109	477,651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	515,045	2,130,990	1,175,884	1,180,968	2,176,547	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,767	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,962	0	0	0	192.00
192.01	19201	VACANT SPACE	0	1,866	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	515,045	2,154,585	1,175,884	1,180,968	2,176,547	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
		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	455,590					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	639,981				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,073	24,798	0	0	21,903,333	30.00
31.00	03100	INTENSIVE CARE UNIT	1,247	3,193	0	0	4,385,366	31.00
41.00	04100	SUBPROVIDER - IRF	191	14,701	0	0	7,724,924	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	366,522	83,745	0	0	6,641,590	50.00
51.00	05100	RECOVERY ROOM	129	6,895	0	0	1,537,450	51.00
53.00	05300	ANESTHESIOLOGY	3,762	12,821	0	0	1,189,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,707	0	0	5,736,451	54.00
56.00	05600	RADIOISOTOPE	20,102	26,910	0	0	2,237,436	56.00
57.00	05700	CT SCAN	381	86,644	0	0	2,117,528	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	21,933	0	0	1,116,007	58.00
60.00	06000	LABORATORY	45,386	101,104	0	0	9,690,713	60.00
65.00	06500	RESPIRATORY THERAPY	6,997	8,796	0	0	2,366,542	65.00
66.00	06600	PHYSICAL THERAPY	5	44,930	0	0	12,264,243	66.00
69.00	06900	ELECTROCARDIOLOGY	3,412	28,193	0	0	2,003,196	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	159	24,587	0	0	4,924,083	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,738	0	0	14,956,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20	40,696	0	0	9,255,226	73.00
76.97	07697	CARDIAC REHABILITATION	0	2,124	0	0	881,898	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,389	3,747	0	0	850,132	90.00
91.00	09100	EMERGENCY	815	43,719	0	0	8,103,821	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	455,590	639,981	0	0	119,885,060	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	45,728	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	128,482	192.00
192.01	19201	VACANT SPACE	0	0	0	0	6,196	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	455,590	639,981	0	0	120,065,466	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	21,903,333		30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,385,366		31.00
41.00	04100	SUBPROVIDER - IRF	0	7,724,924		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,641,590		50.00
51.00	05100	RECOVERY ROOM	0	1,537,450		51.00
53.00	05300	ANESTHESIOLOGY	0	1,189,069		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,736,451		54.00
56.00	05600	RADIOISOTOPE	0	2,237,436		56.00
57.00	05700	CT SCAN	0	2,117,528		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,116,007		58.00
60.00	06000	LABORATORY	0	9,690,713		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,366,542		65.00
66.00	06600	PHYSICAL THERAPY	0	12,264,243		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,003,196		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,924,083		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,956,052		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,255,226		73.00
76.97	07697	CARDIAC REHABILITATION	0	881,898		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	850,132		90.00
91.00	09100	EMERGENCY	0	8,103,821		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	119,885,060		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	45,728		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	128,482		192.00
192.01	19201	VACANT SPACE	0	6,196		192.01
192.02	19202	REFERENCE LAB	0	0		192.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	120,065,466		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet Non-CMS W | Date/Time Prepared: 8/15/2017 5:50 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	9	MEALS SERVED	10.00
11.00	CAFETERIA	4	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	10	DIRECT NURSING HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	8	PATIENT DAYS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	12	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	27,213	4,588	31,801	31,801	4.00
5.01	00550	DATA PROCESSING	0	17,583	0	17,583	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	31,418	1,560	32,978	149	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	25,840	6,923	32,763	678	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	694,229	99,413	793,642	2,274	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	466,420	11,659	478,079	377	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	576	576	28	8.00
9.00	00900	HOUSEKEEPING	0	51,442	19,163	70,605	764	9.00
10.00	01000	DIETARY	0	57,868	31,597	89,465	268	10.00
11.00	01100	CAFETERIA	0	70,279	0	70,279	469	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,328	309,435	325,763	754	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,370	713	40,083	119	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16,138	16,138	235	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	644,720	273,954	918,674	6,008	30.00
31.00	03100	INTENSIVE CARE UNIT	0	74,874	116,749	191,623	1,229	31.00
41.00	04100	SUBPROVIDER - IRF	0	301,616	92,593	394,209	2,283	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	505,552	1,706,317	2,211,869	2,779	50.00
51.00	05100	RECOVERY ROOM	0	28,383	194,002	222,385	500	51.00
53.00	05300	ANESTHESIOLOGY	0	475	57,285	57,760	298	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	115,770	749,417	865,187	1,428	54.00
56.00	05600	RADIOISOTOPE	0	26,094	160,169	186,263	165	56.00
57.00	05700	CT SCAN	0	17,294	219,233	236,527	319	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,394	287,478	299,872	207	58.00
60.00	06000	LABORATORY	0	98,204	429,622	527,826	1,338	60.00
65.00	06500	RESPIRATORY THERAPY	0	53,511	103,215	156,726	727	65.00
66.00	06600	PHYSICAL THERAPY	0	122,162	74,512	196,674	3,884	66.00
69.00	06900	ELECTROCARDIOLOGY	0	44,083	144,494	188,577	514	69.00
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	34,114	71,435	105,549	1,282	73.00
76.97	07697	CARDIAC REHABILITATION	0	31,842	13,346	45,188	302	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	319	319	129	90.00
91.00	09100	EMERGENCY	0	164,330	193,018	357,348	2,294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,773,408	5,388,923	9,162,331	31,801	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,734	0	14,734	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,343	3,117	13,460	0	192.00
192.01	19201	VACANT SPACE	0	2,153	0	2,153	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,800,638	5,392,040	9,192,678	31,801	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	17,583					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	139	33,266				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	693	154	34,288			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,433	0	0	797,349		5.04
6.00	00600	MAINTENANCE & REPAIRS	439	1	0	18,145	497,041	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	3,420	0	8.00
9.00	00900	HOUSEKEEPING	46	2	0	13,941	10,075	9.00
10.00	01000	DIETARY	185	2	0	7,062	11,333	10.00
11.00	01100	CAFETERIA	0	4	0	6,936	13,764	11.00
13.00	01300	NURSING ADMINISTRATION	185	4	0	14,023	3,198	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23	67	0	2,483	7,710	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	485	0	0	4,181	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,279	6,790	1,324	121,215	126,262	30.00
31.00	03100	INTENSIVE CARE UNIT	347	1,948	171	23,730	14,664	31.00
41.00	04100	SUBPROVIDER - IRF	1,640	1,049	785	42,407	59,070	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	809	15,604	4,473	33,551	99,010	50.00
51.00	05100	RECOVERY ROOM	92	172	368	9,630	5,559	51.00
53.00	05300	ANESTHESIOLOGY	116	728	685	7,693	93	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	786	0	2,174	35,913	22,673	54.00
56.00	05600	RADIOISOTOPE	116	84	1,437	14,161	5,110	56.00
57.00	05700	CT SCAN	46	759	4,627	13,168	3,387	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23	45	1,171	7,045	2,427	58.00
60.00	06000	LABORATORY	947	1,047	5,509	61,724	19,233	60.00
65.00	06500	RESPIRATORY THERAPY	624	574	470	14,708	10,480	65.00
66.00	06600	PHYSICAL THERAPY	2,981	205	2,400	78,434	23,925	66.00
69.00	06900	ELECTROCARDIOLOGY	670	144	1,506	12,374	8,634	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,313	32,536	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,054	99,191	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	393	71	2,173	60,357	6,681	73.00
76.97	07697	CARDIAC REHABILITATION	231	12	113	5,343	6,236	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	46	192	200	5,574	0	90.00
91.00	09100	EMERGENCY	786	3,608	2,335	47,557	32,183	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,560	33,266	34,288	796,502	491,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	114	2,886	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23	0	0	720	2,026	192.00
192.01	19201	VACANT SPACE	0	0	0	13	422	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,583	33,266	34,288	797,349	497,041	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	4,024					8.00
9.00	00900	HOUSEKEEPING	0	95,433				9.00
10.00	01000	DIETARY	0	2,221	110,536			10.00
11.00	01100	CAFETERIA	0	2,697	0	94,149		11.00
13.00	01300	NURSING ADMINISTRATION	0	627	0	2,648	347,202	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,511	0	418	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	824	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,678	24,744	73,556	21,138	156,049	30.00
31.00	03100	INTENSIVE CARE UNIT	305	2,874	8,386	4,317	76,528	31.00
41.00	04100	SUBPROVIDER - IRF	1,041	11,576	28,594	8,019	31,942	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	19,403	0	9,761	5,490	50.00
51.00	05100	RECOVERY ROOM	0	1,089	0	1,756	499	51.00
53.00	05300	ANESTHESIOLOGY	0	18	0	1,047	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,443	0	5,015	0	54.00
56.00	05600	RADIOISOTOPE	0	1,002	0	580	0	56.00
57.00	05700	CT SCAN	0	664	0	1,122	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	476	0	728	0	58.00
60.00	06000	LABORATORY	0	3,769	0	4,700	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,054	0	2,555	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,689	0	13,643	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,692	0	1,804	0	69.00
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	1,309	0	4,501	499	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,222	0	1,061	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	453	0	90.00
91.00	09100	EMERGENCY	0	6,307	0	8,059	76,195	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,024	94,387	110,536	94,149	347,202	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	566	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	397	0	0	0	192.00
192.01	19201	VACANT SPACE	0	83	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,024	95,433	110,536	94,149	347,202	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
		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	52,414					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,863				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	584	845	0		1,463,146	30.00
31.00	03100	INTENSIVE CARE UNIT	143	109	0		326,374	31.00
41.00	04100	SUBPROVIDER - IRF	22	501	0		583,138	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,166	2,853	0		2,447,768	50.00
51.00	05100	RECOVERY ROOM	15	235	0		242,300	51.00
53.00	05300	ANESTHESIOLOGY	433	437	0		69,308	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,387	0		939,006	54.00
56.00	05600	RADIOISOTOPE	2,313	917	0		212,148	56.00
57.00	05700	CT SCAN	44	2,952	0		263,615	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	747	0		312,741	58.00
60.00	06000	LABORATORY	5,221	3,501	0		634,815	60.00
65.00	06500	RESPIRATORY THERAPY	805	300	0		190,023	65.00
66.00	06600	PHYSICAL THERAPY	1	1,531	0		328,367	66.00
69.00	06900	ELECTROCARDIOLOGY	393	961	0		217,269	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18	838	0		34,705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	672	0		100,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2	1,387	0		184,204	73.00
76.97	07697	CARDIAC REHABILITATION	0	72	0		59,780	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	160	128	0		7,201	90.00
91.00	09100	EMERGENCY	94	1,490	0		538,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,414	21,863	0	0	9,155,081	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		18,300	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		16,626	192.00
192.01	19201	VACANT SPACE	0	0	0		2,671	192.01
192.02	19202	REFERENCE LAB	0	0	0		0	192.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	52,414	21,863	0	0	9,192,678	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,463,146		30.00
31.00	03100	INTENSIVE CARE UNIT	0	326,374		31.00
41.00	04100	SUBPROVIDER - IRF	0	583,138		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,447,768		50.00
51.00	05100	RECOVERY ROOM	0	242,300		51.00
53.00	05300	ANESTHESIOLOGY	0	69,308		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	939,006		54.00
56.00	05600	RADIOISOTOPE	0	212,148		56.00
57.00	05700	CT SCAN	0	263,615		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	312,741		58.00
60.00	06000	LABORATORY	0	634,815		60.00
65.00	06500	RESPIRATORY THERAPY	0	190,023		65.00
66.00	06600	PHYSICAL THERAPY	0	328,367		66.00
69.00	06900	ELECTROCARDIOLOGY	0	217,269		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34,705		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	100,917		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	184,204		73.00
76.97	07697	CARDIAC REHABILITATION	0	59,780		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	7,201		90.00
91.00	09100	EMERGENCY	0	538,256		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	9,155,081		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,300		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,626		192.00
192.01	19201	VACANT SPACE	0	2,671		192.01
192.02	19202	REFERENCE LAB	0	0		192.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	9,192,678		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	224,158					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,957,915				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,605	2,517	44,052,113			4.00
5.01	00550	DATA PROCESSING	1,037	0	0	761		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,853	856	205,751	6	5,737,041	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,524	3,798	939,295	30	26,572	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	40,945	54,535	3,149,292	62	2	5.04
6.00	00600	MAINTENANCE & REPAIRS	27,509	6,396	522,425	19	104	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	316	38,757	0	0	8.00
9.00	00900	HOUSEKEEPING	3,034	10,512	1,058,065	2	399	9.00
10.00	01000	DIETARY	3,413	17,333	370,615	8	390	10.00
11.00	01100	CAFETERIA	4,145	0	649,795	0	683	11.00
13.00	01300	NURSING ADMINISTRATION	963	169,747	1,044,141	8	734	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,322	391	164,834	1	11,590	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,853	324,923	21	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,025	150,283	8,328,255	142	1,171,144	30.00
31.00	03100	INTENSIVE CARE UNIT	4,416	64,045	1,702,481	15	335,932	31.00
41.00	04100	SUBPROVIDER - IRF	17,789	50,794	3,162,180	71	180,943	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,817	936,035	3,848,909	35	2,690,564	50.00
51.00	05100	RECOVERY ROOM	1,674	106,424	692,587	4	29,597	51.00
53.00	05300	ANESTHESIOLOGY	28	31,425	412,823	5	125,529	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,828	411,108	1,977,345	34	0	54.00
56.00	05600	RADIOISOTOPE	1,539	87,864	228,540	5	14,543	56.00
57.00	05700	CT SCAN	1,020	120,265	442,302	2	130,893	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731	157,702	287,049	1	7,778	58.00
60.00	06000	LABORATORY	5,792	235,678	1,853,370	41	180,654	60.00
65.00	06500	RESPIRATORY THERAPY	3,156	56,621	1,007,373	27	98,976	65.00
66.00	06600	PHYSICAL THERAPY	7,205	40,875	5,379,644	129	35,410	66.00
69.00	06900	ELECTROCARDIOLOGY	2,600	79,265	711,480	29	24,873	69.00
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	2,012	39,187	1,775,014	17	12,324	73.00
76.97	07697	CARDIAC REHABILITATION	1,878	7,321	418,203	10	2,035	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	175	178,729	2	33,077	90.00
91.00	09100	EMERGENCY	9,692	105,884	3,177,936	34	622,295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	222,552	2,956,205	44,052,113	760	5,737,041	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	869	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	610	1,710	0	1	0	192.00
192.01	19201	VACANT SPACE	127	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	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)	3,800,638	5,392,040	14,484,738	4,763,830	434,867	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.955174	1.822919	0.328809	6,259.960578	0.075800	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			31,801	17,583	33,266	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000722	23.105125	0.005798	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.03	5A.04	5.04	6.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	589,372,738					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-16,608,109	103,457,357			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	2,354,355	149,685		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	443,801	0	28,444	8.00
9.00	00900	HOUSEKEEPING	0	0	1,808,830	3,034	0	9.00
10.00	01000	DIETARY	0	0	916,339	3,413	0	10.00
11.00	01100	CAFETERIA	0	0	899,941	4,145	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,819,513	963	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	322,134	2,322	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	542,547	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,834,000	0	15,727,493	38,025	18,928	30.00
31.00	03100	INTENSIVE CARE UNIT	2,940,212	0	3,078,976	4,416	2,158	31.00
41.00	04100	SUBPROVIDER - IRF	13,537,098	0	5,502,395	17,789	7,358	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77,113,433	0	4,353,275	29,817	0	50.00
51.00	05100	RECOVERY ROOM	6,348,532	0	1,249,524	1,674	0	51.00
53.00	05300	ANESTHESIOLOGY	11,805,283	0	998,190	28	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,483,378	0	4,659,833	6,828	0	54.00
56.00	05600	RADIOISOTOPE	24,778,703	0	1,837,478	1,539	0	56.00
57.00	05700	CT SCAN	79,782,926	0	1,708,551	1,020	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,196,340	0	914,114	731	0	58.00
60.00	06000	LABORATORY	93,170,691	0	8,008,778	5,792	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,099,289	0	1,908,369	3,156	0	65.00
66.00	06600	PHYSICAL THERAPY	41,371,646	0	10,177,045	7,205	0	66.00
69.00	06900	ELECTROCARDIOLOGY	25,960,186	0	1,605,555	2,600	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,640,068	0	4,221,634	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,174,574	0	12,870,241	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,473,073	0	7,831,433	2,012	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,956,161	0	693,301	1,878	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,450,096	0	723,212	0	0	90.00
91.00	09100	EMERGENCY	40,257,049	0	6,170,639	9,692	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	589,372,738	-16,608,109	103,347,496	148,079	28,444	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	14,734	869	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	93,393	610	0	192.00
192.01	19201	VACANT SPACE	0	0	1,734	127	0	192.01
192.02	19202	REFERENCE LAB	0	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)	3,919,055		16,608,109	2,732,302	515,045	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006650		0.160531	18.253679	18.107334	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	34,288		797,349	497,041	4,024	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000058		0.007707	3.320580	0.141471	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (DIRECT NURSING HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		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	146,651					9.00
10.00	01000	DIETARY	3,413	85,332				10.00
11.00	01100	CAFETERIA	4,145	0	37,118,118			11.00
13.00	01300	NURSING ADMINISTRATION	963	0	1,044,141	10,435		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,322	0	164,834	0	4,527,312	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	324,923	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,025	56,784	8,328,255	4,690	50,413	30.00
31.00	03100	INTENSIVE CARE UNIT	4,416	6,474	1,702,481	2,300	12,392	31.00
41.00	04100	SUBPROVIDER - IRF	17,789	22,074	3,162,180	960	1,900	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,817	0	3,848,909	165	3,642,217	50.00
51.00	05100	RECOVERY ROOM	1,674	0	692,587	15	1,280	51.00
53.00	05300	ANESTHESIOLOGY	28	0	412,823	0	37,386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,828	0	1,977,345	0	0	54.00
56.00	05600	RADIOISOTOPE	1,539	0	228,540	0	199,759	56.00
57.00	05700	CT SCAN	1,020	0	442,302	0	3,784	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731	0	287,049	0	0	58.00
60.00	06000	LABORATORY	5,792	0	1,853,370	0	451,019	60.00
65.00	06500	RESPIRATORY THERAPY	3,156	0	1,007,373	0	69,534	65.00
66.00	06600	PHYSICAL THERAPY	7,205	0	5,379,644	0	45	66.00
69.00	06900	ELECTROCARDIOLOGY	2,600	0	711,480	0	33,907	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,012	0	1,775,014	15	194	73.00
76.97	07697	CARDIAC REHABILITATION	1,878	0	418,203	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	178,729	0	13,801	90.00
91.00	09100	EMERGENCY	9,692	0	3,177,936	2,290	8,099	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	145,045	85,332	37,118,118	10,435	4,527,312	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	869	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	610	0	0	0	0	192.00
192.01	19201	VACANT SPACE	127	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	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)	2,154,585	1,175,884	1,180,968	2,176,547	455,590	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.691922	13.780106	0.031816	208.581409	0.100631	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	95,433	110,536	94,149	347,202	52,414	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.650749	1.295364	0.002536	33.272832	0.011577	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/15/2017 5:50 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	589,372,738				16.00
17.00	01700	SOCIAL SERVICE	0	28,444			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	22,834,000	18,928	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,940,212	2,158	0		31.00
41.00	04100	SUBPROVIDER - IRF	13,537,098	7,358	0		41.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	77,113,433	0	0		50.00
51.00	05100	RECOVERY ROOM	6,348,532	0	0		51.00
53.00	05300	ANESTHESIOLOGY	11,805,283	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,483,378	0	0		54.00
56.00	05600	RADIOISOTOPE	24,778,703	0	0		56.00
57.00	05700	CT SCAN	79,782,926	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,196,340	0	0		58.00
60.00	06000	LABORATORY	93,170,691	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	8,099,289	0	0		65.00
66.00	06600	PHYSICAL THERAPY	41,371,646	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	25,960,186	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,640,068	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,174,574	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,473,073	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	1,956,161	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3,450,096	0	0		90.00
91.00	09100	EMERGENCY	40,257,049	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	589,372,738	28,444	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	VACANT SPACE	0	0	0		192.01
192.02	19202	REFERENCE LAB	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)	639,981	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001086	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,863	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000037	0.000000	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,903,333		21,903,333	0	21,903,333	30.00
31.00	03100	INTENSIVE CARE UNIT	4,385,366		4,385,366	0	4,385,366	31.00
41.00	04100	SUBPROVIDER - IRF	7,724,924		7,724,924	0	7,724,924	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,641,590		6,641,590	26,817	6,668,407	50.00
51.00	05100	RECOVERY ROOM	1,537,450		1,537,450	0	1,537,450	51.00
53.00	05300	ANESTHESIOLOGY	1,189,069		1,189,069	0	1,189,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,736,451		5,736,451	0	5,736,451	54.00
56.00	05600	RADIOISOTOPE	2,237,436		2,237,436	0	2,237,436	56.00
57.00	05700	CT SCAN	2,117,528		2,117,528	0	2,117,528	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,116,007		1,116,007	0	1,116,007	58.00
60.00	06000	LABORATORY	9,690,713		9,690,713	112,040	9,802,753	60.00
65.00	06500	RESPIRATORY THERAPY	2,366,542	0	2,366,542	10,874	2,377,416	65.00
66.00	06600	PHYSICAL THERAPY	12,264,243	0	12,264,243	0	12,264,243	66.00
69.00	06900	ELECTROCARDIOLOGY	2,003,196		2,003,196	770	2,003,966	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,924,083		4,924,083	0	4,924,083	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,956,052		14,956,052	0	14,956,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,255,226		9,255,226	0	9,255,226	73.00
76.97	07697	CARDIAC REHABILITATION	881,898		881,898	411	882,309	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	850,132		850,132	0	850,132	90.00
91.00	09100	EMERGENCY	8,103,821		8,103,821	6,778	8,110,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,343,683		2,343,683		2,343,683	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	122,228,743	0	122,228,743	157,690	122,386,433	200.00
201.00		Less Observation Beds	2,343,683		2,343,683		2,343,683	201.00
202.00		Total (see instructions)	119,885,060	0	119,885,060	157,690	120,042,750	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,458,090		18,458,090			30.00
31.00	03100	INTENSIVE CARE UNIT	2,940,212		2,940,212			31.00
41.00	04100	SUBPROVIDER - IRF	12,276,180		12,276,180			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,988,106	42,585,276	76,573,382	0.086735	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,445,610	2,761,078	6,206,688	0.247709	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	5,133,114	6,568,241	11,701,355	0.101618	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,878,591	32,188,012	37,066,603	0.154761	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,845,927	21,734,878	24,580,805	0.091024	0.000000	56.00
57.00	05700	CT SCAN	19,110,673	60,162,425	79,273,098	0.026712	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,724,738	16,173,500	19,898,238	0.056086	0.000000	58.00
60.00	06000	LABORATORY	23,071,215	69,443,176	92,514,391	0.104748	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,027,185	2,042,384	8,069,569	0.293267	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,339,029	29,486,697	40,825,726	0.300405	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	7,952,311	16,170,715	24,123,026	0.083041	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,862,498	7,660,763	22,523,261	0.218622	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,093,732	4,065,226	18,158,958	0.823618	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,676,868	12,661,319	37,338,187	0.247876	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	1,446	1,934,681	1,936,127	0.455496	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	87,721	3,299,172	3,386,893	0.251006	0.000000	90.00
91.00	09100	EMERGENCY	9,681,082	30,340,788	40,021,870	0.202485	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	786,878	3,558,228	4,345,106	0.539385	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	219,381,206	362,836,559	582,217,765			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	219,381,206	362,836,559	582,217,765			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.087085	50.00
51.00	05100	RECOVERY ROOM	0.247709	51.00
53.00	05300	ANESTHESIOLOGY	0.101618	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154761	54.00
56.00	05600	RADIOISOTOPE	0.091024	56.00
57.00	05700	CT SCAN	0.026712	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056086	58.00
60.00	06000	LABORATORY	0.105959	60.00
65.00	06500	RESPIRATORY THERAPY	0.294615	65.00
66.00	06600	PHYSICAL THERAPY	0.300405	66.00
69.00	06900	ELECTROCARDIOLOGY	0.083073	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218622	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.823618	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247876	73.00
76.97	07697	CARDIAC REHABILITATION	0.455708	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.251006	90.00
91.00	09100	EMERGENCY	0.202654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.539385	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: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/15/2017 5:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,903,333		21,903,333	0	21,903,333	30.00
31.00	03100	INTENSIVE CARE UNIT	4,385,366		4,385,366	0	4,385,366	31.00
41.00	04100	SUBPROVIDER - IRF	7,724,924		7,724,924	0	7,724,924	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,641,590		6,641,590	26,817	6,668,407	50.00
51.00	05100	RECOVERY ROOM	1,537,450		1,537,450	0	1,537,450	51.00
53.00	05300	ANESTHESIOLOGY	1,189,069		1,189,069	0	1,189,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,736,451		5,736,451	0	5,736,451	54.00
56.00	05600	RADIOISOTOPE	2,237,436		2,237,436	0	2,237,436	56.00
57.00	05700	CT SCAN	2,117,528		2,117,528	0	2,117,528	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,116,007		1,116,007	0	1,116,007	58.00
60.00	06000	LABORATORY	9,690,713		9,690,713	112,040	9,802,753	60.00
65.00	06500	RESPIRATORY THERAPY	2,366,542	0	2,366,542	10,874	2,377,416	65.00
66.00	06600	PHYSICAL THERAPY	12,264,243	0	12,264,243	0	12,264,243	66.00
69.00	06900	ELECTROCARDIOLOGY	2,003,196		2,003,196	770	2,003,966	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,924,083		4,924,083	0	4,924,083	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,956,052		14,956,052	0	14,956,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,255,226		9,255,226	0	9,255,226	73.00
76.97	07697	CARDIAC REHABILITATION	881,898		881,898	411	882,309	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	850,132		850,132	0	850,132	90.00
91.00	09100	EMERGENCY	8,103,821		8,103,821	6,778	8,110,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,343,683		2,343,683		2,343,683	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	122,228,743	0	122,228,743	157,690	122,386,433	200.00
201.00		Less Observation Beds	2,343,683		2,343,683		2,343,683	201.00
202.00		Total (see instructions)	119,885,060	0	119,885,060	157,690	120,042,750	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/15/2017 5:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,458,090		18,458,090			30.00
31.00	03100	INTENSIVE CARE UNIT	2,940,212		2,940,212			31.00
41.00	04100	SUBPROVIDER - IRF	12,276,180		12,276,180			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,988,106	42,585,276	76,573,382	0.086735	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,445,610	2,761,078	6,206,688	0.247709	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	5,133,114	6,568,241	11,701,355	0.101618	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,878,591	32,188,012	37,066,603	0.154761	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,845,927	21,734,878	24,580,805	0.091024	0.000000	56.00
57.00	05700	CT SCAN	19,110,673	60,162,425	79,273,098	0.026712	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,724,738	16,173,500	19,898,238	0.056086	0.000000	58.00
60.00	06000	LABORATORY	23,071,215	69,443,176	92,514,391	0.104748	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,027,185	2,042,384	8,069,569	0.293267	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,339,029	29,486,697	40,825,726	0.300405	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	7,952,311	16,170,715	24,123,026	0.083041	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,862,498	7,660,763	22,523,261	0.218622	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,093,732	4,065,226	18,158,958	0.823618	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,676,868	12,661,319	37,338,187	0.247876	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	1,446	1,934,681	1,936,127	0.455496	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	87,721	3,299,172	3,386,893	0.251006	0.000000	90.00
91.00	09100	EMERGENCY	9,681,082	30,340,788	40,021,870	0.202485	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	786,878	3,558,228	4,345,106	0.539385	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	219,381,206	362,836,559	582,217,765			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	219,381,206	362,836,559	582,217,765			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/15/2017 5:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT 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: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part I Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,463,146	0	1,463,146	21,196	69.03	30.00
31.00	INTENSIVE CARE UNIT	326,374		326,374	2,158	151.24	31.00
41.00	SUBPROVIDER - IRF	583,138	0	583,138	7,358	79.25	41.00
200.00	Total (lines 30-199)	2,372,658		2,372,658	30,712		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,474	792,050				30.00
31.00	INTENSIVE CARE UNIT	1,289	194,948				31.00
41.00	SUBPROVIDER - IRF	4,756	376,913				41.00
200.00	Total (lines 30-199)	17,519	1,363,911				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part II Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,447,768	76,573,382	0.031966	15,443,407	493,664	50.00
51.00	05100	RECOVERY ROOM	242,300	6,206,688	0.039039	1,423,480	55,571	51.00
53.00	05300	ANESTHESIOLOGY	69,308	11,701,355	0.005923	2,305,885	13,658	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	939,006	37,066,603	0.025333	2,606,235	66,024	54.00
56.00	05600	RADIOISOTOPE	212,148	24,580,805	0.008631	1,674,644	14,454	56.00
57.00	05700	CT SCAN	263,615	79,273,098	0.003325	11,619,387	38,634	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	312,741	19,898,238	0.015717	1,907,405	29,979	58.00
60.00	06000	LABORATORY	634,815	92,514,391	0.006862	13,637,824	93,583	60.00
65.00	06500	RESPIRATORY THERAPY	190,023	8,069,569	0.023548	3,367,926	79,308	65.00
66.00	06600	PHYSICAL THERAPY	328,367	40,825,726	0.008043	2,179,216	17,527	66.00
69.00	06900	ELECTROCARDIOLOGY	217,269	24,123,026	0.009007	5,024,561	45,256	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,705	22,523,261	0.001541	4,611,046	7,106	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,917	18,158,958	0.005557	7,566,491	42,047	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184,204	37,338,187	0.004933	12,303,041	60,691	73.00
76.97	07697	CARDIAC REHABILITATION	59,780	1,936,127	0.030876	624	19	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,201	3,386,893	0.002126	86,995	185	90.00
91.00	09100	EMERGENCY	538,256	40,021,870	0.013449	4,908,822	66,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	156,558	4,345,106	0.036031	314,640	11,337	92.00
200.00		Total (lines 50-199)	6,938,981	548,543,283		90,981,629	1,135,062	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part III Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,196	0.00	11,474	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,158	0.00	1,289	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	7,358	0.00	4,756	0	0	41.00
200.00		Total (lines 30-199)	30,712		17,519	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
			12.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	76,573,382	0.000000	0.000000	15,443,407	50.00
51.00	05100	RECOVERY ROOM	0	6,206,688	0.000000	0.000000	1,423,480	51.00
53.00	05300	ANESTHESIOLOGY	0	11,701,355	0.000000	0.000000	2,305,885	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,066,603	0.000000	0.000000	2,606,235	54.00
56.00	05600	RADIOISOTOPE	0	24,580,805	0.000000	0.000000	1,674,644	56.00
57.00	05700	CT SCAN	0	79,273,098	0.000000	0.000000	11,619,387	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,898,238	0.000000	0.000000	1,907,405	58.00
60.00	06000	LABORATORY	0	92,514,391	0.000000	0.000000	13,637,824	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,069,569	0.000000	0.000000	3,367,926	65.00
66.00	06600	PHYSICAL THERAPY	0	40,825,726	0.000000	0.000000	2,179,216	66.00
69.00	06900	ELECTROCARDIOLOGY	0	24,123,026	0.000000	0.000000	5,024,561	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,523,261	0.000000	0.000000	4,611,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,158,958	0.000000	0.000000	7,566,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,338,187	0.000000	0.000000	12,303,041	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,936,127	0.000000	0.000000	624	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,386,893	0.000000	0.000000	86,995	90.00
91.00	09100	EMERGENCY	0	40,021,870	0.000000	0.000000	4,908,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,345,106	0.000000	0.000000	314,640	92.00
200.00		Total (lines 50-199)	0	548,543,283			90,981,629	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,102,219	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	968,061	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,935,657	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,627,745	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	9,888,480	0	0	0	56.00
57.00	05700	CT SCAN	0	20,001,545	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,859,698	0	0	0	58.00
60.00	06000	LABORATORY	0	8,410,741	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	748,387	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	72,835	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,088,299	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,084,761	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,582,759	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,505,838	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	707,934	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,896,164	0	0	0	90.00
91.00	09100	EMERGENCY	0	7,535,374	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,426,297	0	0	0	92.00
200.00		Total (lines 50-199)	0	95,442,794	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.086735	13,102,219	0	0	1,136,421	50.00
51.00	05100	RECOVERY ROOM	0.247709	968,061	0	0	239,797	51.00
53.00	05300	ANESTHESIOLOGY	0.101618	1,935,657	0	0	196,698	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154761	9,627,745	0	0	1,489,999	54.00
56.00	05600	RADIOISOTOPE	0.091024	9,888,480	0	0	900,089	56.00
57.00	05700	CT SCAN	0.026712	20,001,545	0	0	534,281	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056086	4,859,698	0	0	272,561	58.00
60.00	06000	LABORATORY	0.104748	8,410,741	2,328	0	881,008	60.00
65.00	06500	RESPIRATORY THERAPY	0.293267	748,387	0	0	219,477	65.00
66.00	06600	PHYSICAL THERAPY	0.300405	72,835	0	0	21,880	66.00
69.00	06900	ELECTROCARDIOLOGY	0.083041	7,088,299	0	0	588,619	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218622	2,084,761	0	0	455,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.823618	1,582,759	0	0	1,303,589	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247876	3,505,838	0	30,878	869,013	73.00
76.97	07697	CARDIAC REHABILITATION	0.455496	707,934	0	0	322,461	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.251006	1,896,164	0	0	475,949	90.00
91.00	09100	EMERGENCY	0.202485	7,535,374	0	0	1,525,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.539385	1,426,297	0	0	769,323	92.00
200.00		Subtotal (see instructions)		95,442,794	2,328	30,878	12,202,740	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		95,442,794	2,328	30,878	12,202,740	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	244	0		60.00
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
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	7,654		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	244	7,654		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	244	7,654		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part II Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,447,768	76,573,382	0.031966	39,149	1,251	50.00
51.00	05100	RECOVERY ROOM	242,300	6,206,688	0.039039	1,699	66	51.00
53.00	05300	ANESTHESIOLOGY	69,308	11,701,355	0.005923	2,052	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	939,006	37,066,603	0.025333	213,750	5,415	54.00
56.00	05600	RADIOISOTOPE	212,148	24,580,805	0.008631	54,076	467	56.00
57.00	05700	CT SCAN	263,615	79,273,098	0.003325	314,843	1,047	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	312,741	19,898,238	0.015717	58,033	912	58.00
60.00	06000	LABORATORY	634,815	92,514,391	0.006862	1,020,201	7,001	60.00
65.00	06500	RESPIRATORY THERAPY	190,023	8,069,569	0.023548	256,933	6,050	65.00
66.00	06600	PHYSICAL THERAPY	328,367	40,825,726	0.008043	5,123,077	41,205	66.00
69.00	06900	ELECTROCARDIOLOGY	217,269	24,123,026	0.009007	69,827	629	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,705	22,523,261	0.001541	31,005	48	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,917	18,158,958	0.005557	41,914	233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184,204	37,338,187	0.004933	1,734,621	8,557	73.00
76.97	07697	CARDIAC REHABILITATION	59,780	1,936,127	0.030876	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,201	3,386,893	0.002126	726	2	90.00
91.00	09100	EMERGENCY	538,256	40,021,870	0.013449	1,253	17	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,345,106	0.000000	0	0	92.00
200.00		Total (lines 50-199)	6,782,423	548,543,283		8,963,159	72,912	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011
Component CCN: 14-T011

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

Worksheet D
Part IV
Date/Time Prepared:
8/15/2017 5:50 pm

Title XVIII

Subprovider - IRF

PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	76,573,382	0.000000	0.000000	39,149	50.00
51.00	05100	RECOVERY ROOM	0	6,206,688	0.000000	0.000000	1,699	51.00
53.00	05300	ANESTHESIOLOGY	0	11,701,355	0.000000	0.000000	2,052	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,066,603	0.000000	0.000000	213,750	54.00
56.00	05600	RADIOISOTOPE	0	24,580,805	0.000000	0.000000	54,076	56.00
57.00	05700	CT SCAN	0	79,273,098	0.000000	0.000000	314,843	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,898,238	0.000000	0.000000	58,033	58.00
60.00	06000	LABORATORY	0	92,514,391	0.000000	0.000000	1,020,201	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,069,569	0.000000	0.000000	256,933	65.00
66.00	06600	PHYSICAL THERAPY	0	40,825,726	0.000000	0.000000	5,123,077	66.00
69.00	06900	ELECTROCARDIOLOGY	0	24,123,026	0.000000	0.000000	69,827	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,523,261	0.000000	0.000000	31,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,158,958	0.000000	0.000000	41,914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,338,187	0.000000	0.000000	1,734,621	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,936,127	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,386,893	0.000000	0.000000	726	90.00
91.00	09100	EMERGENCY	0	40,021,870	0.000000	0.000000	1,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,345,106	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	548,543,283			8,963,159	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,041	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	8,096	0	0	0	56.00
57.00	05700	CT SCAN	0	11,545	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,012	0	0	0	58.00
60.00	06000	LABORATORY	0	696	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	516	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,969	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,660	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,601	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,114	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	630	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	43,880	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part IV Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.086735	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.247709	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.101618	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154761	9,041	0	0	1,399	54.00
56.00	05600	RADIOISOTOPE	0.091024	8,096	0	0	737	56.00
57.00	05700	CT SCAN	0.026712	11,545	0	0	308	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056086	3,012	0	0	169	58.00
60.00	06000	LABORATORY	0.104748	696	0	0	73	60.00
65.00	06500	RESPIRATORY THERAPY	0.293267	516	0	0	151	65.00
66.00	06600	PHYSICAL THERAPY	0.300405	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.083041	5,969	0	0	496	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218622	1,660	0	0	363	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.823618	1,601	0	0	1,319	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247876	1,114	0	721	276	73.00
76.97	07697	CARDIAC REHABILITATION	0.455496	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.251006	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.202485	630	0	0	128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.539385	0	0	0	0	92.00
200.00		Subtotal (see instructions)		43,880	0	721	5,419	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		43,880	0	721	5,419	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	179		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	179		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	179		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,196	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,196	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)	18,928	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)	11,474	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)	21,903,333	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)	21,903,333	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)	21,903,333	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)	1,033.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	11,856,887	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)	11,856,887	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,385,366	2,158	2,032.14	1,289	2,619,428	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	17,890,521	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	32,366,836	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)	986,998	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,135,062	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,122,060	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	30,244,776	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)	2,268	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,033.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,343,683	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,463,146	21,903,333	0.066800	2,343,683	156,558	90.00
91.00	Nursing School cost	0	21,903,333	0.000000	2,343,683	0	91.00
92.00	Allied health cost	0	21,903,333	0.000000	2,343,683	0	92.00
93.00	All other Medical Education	0	21,903,333	0.000000	2,343,683	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2016 To 03/31/2017	Worksheet D-1 Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,358	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,358	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,358	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)	4,756	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)	7,724,924	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)	7,724,924	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)	7,724,924	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)	1,049.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,993,182	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,993,182	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,254,006	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,247,188	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)	376,913	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	72,912	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	449,825	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,797,363	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2016 To 03/31/2017	Worksheet D-1 Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	583,138	7,724,924	0.075488	0	0	90.00
91.00	Nursing School cost	0	7,724,924	0.000000	0	0	91.00
92.00	Allied health cost	0	7,724,924	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,724,924	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-3 | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,747,747		30.00
31.00	03100	INTENSIVE CARE UNIT		1,763,352		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.087085	15,443,407	1,344,889	50.00
51.00	05100	RECOVERY ROOM	0.247709	1,423,480	352,609	51.00
53.00	05300	ANESTHESIOLOGY	0.101618	2,305,885	234,319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154761	2,606,235	403,344	54.00
56.00	05600	RADIOISOTOPE	0.091024	1,674,644	152,433	56.00
57.00	05700	CT SCAN	0.026712	11,619,387	310,377	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056086	1,907,405	106,979	58.00
60.00	06000	LABORATORY	0.105959	13,637,824	1,445,050	60.00
65.00	06500	RESPIRATORY THERAPY	0.294615	3,367,926	992,242	65.00
66.00	06600	PHYSICAL THERAPY	0.300405	2,179,216	654,647	66.00
69.00	06900	ELECTROCARDIOLOGY	0.083073	5,024,561	417,405	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218622	4,611,046	1,008,076	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.823618	7,566,491	6,231,898	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247876	12,303,041	3,049,629	73.00
76.97	07697	CARDIAC REHABILITATION	0.455708	624	284	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.251006	86,995	21,836	90.00
91.00	09100	EMERGENCY	0.202654	4,908,822	994,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.539385	314,640	169,712	92.00
200.00		Total (sum of lines 50-94 and 96-98)		90,981,629	17,890,521	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)		90,981,629		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-3 | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		8,032,145		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.087085	39,149	3,409	50.00
51.00	05100	RECOVERY ROOM	0.247709	1,699	421	51.00
53.00	05300	ANESTHESIOLOGY	0.101618	2,052	209	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154761	213,750	33,080	54.00
56.00	05600	RADIOISOTOPE	0.091024	54,076	4,922	56.00
57.00	05700	CT SCAN	0.026712	314,843	8,410	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056086	58,033	3,255	58.00
60.00	06000	LABORATORY	0.105959	1,020,201	108,099	60.00
65.00	06500	RESPIRATORY THERAPY	0.294615	256,933	75,696	65.00
66.00	06600	PHYSICAL THERAPY	0.300405	5,123,077	1,538,998	66.00
69.00	06900	ELECTROCARDIOLOGY	0.083073	69,827	5,801	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218622	31,005	6,778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.823618	41,914	34,521	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247876	1,734,621	429,971	73.00
76.97	07697	CARDIAC REHABILITATION	0.455708	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.251006	726	182	90.00
91.00	09100	EMERGENCY	0.202654	1,253	254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.539385	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		8,963,159	2,254,006	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		8,963,159		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part A Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	11,442,452	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	11,791,517	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)	264,388	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	2,440,375	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	78.79	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	6.08	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.23	31.00
32.00	Sum of lines 30 and 31	22.31	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.62	33.00
34.00	Disproportionate share adjustment (see instructions)	442,608	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part A Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	510,145	487,713	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	255,073	243,188	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	498,261		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 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)	24,439,226		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	28,898,127		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		27,783,402	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,862,982	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		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)		29,646,384	59.00
60.00	Primary payer payments		3,161	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		29,643,223	61.00
62.00	Deductibles billed to program beneficiaries		2,903,167	62.00
63.00	Coinsurance billed to program beneficiaries		135,282	63.00
64.00	Allowable bad debts (see instructions)		772,118	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		501,877	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		557,568	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		27,106,651	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		27,755	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-57,654	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		190,812	70.93
70.94	HRR adjustment amount (see instructions)		-402,026	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E Part A Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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)		26,865,538	71.00
71.01	Sequestration adjustment (see instructions)		537,311	71.01
72.00	Interim payments		26,928,294	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-600,067	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)	1,676,669	1,667,507	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0131777191	1.0033945320	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	22,095	5,660	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9863	0.9792	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-22,970	-34,684	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet DSH | Date/Time Prepared: 8/15/2017 5:50 pm

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)	6.08	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	16.23	0.00			16.23	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	22.31	0.00			16.23	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	78.79	0.00			78.79	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	7.62	0.00			0.00	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)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater 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)	0.00	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")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	2.31	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)	2,937	0			2,937	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	217	0			217	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)	59	0			59	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	209	0			209	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	3,422	0			3,422	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	21,086	0			21,086	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	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)	21,086	0			21,086	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	16.23	0.00			16.23	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet DSH | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	7.62		0.00	False	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	True	29.00
30.00	Line 28 or 29 as applicable		7.62		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.		7.62		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 ammendment? (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")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00
35.00	Is this a Sole Cummunity 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)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 14-0011	Period: From 04/01/2016 To 03/31/2017	Worksheet DSH Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Hospital	PPS

		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	3.30		29.00
30.00	Line 28 or 29 as applicable	3.30		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.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part B Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,898	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,202,740	2.00
3.00	PPS payments	10,326,766	3.00
4.00	Outlier payment (see instructions)	27,724	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.804	5.00
6.00	Line 2 times line 5	9,811,003	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,898	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	33,206	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)	33,206	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	33,206	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	25,308	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	7,898	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	10,354,490	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	169,897	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,057,609	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	8,134,882	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	8,134,882	30.00
31.00	Primary payer payments	60	31.00
32.00	Subtotal (line 30 minus line 31)	8,134,822	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)	474,990	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	308,744	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	333,086	36.00
37.00	Subtotal (see instructions)	8,443,566	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	8,443,566	40.00
40.01	Sequestration adjustment (see instructions)	168,871	40.01
41.00	Interim payments	8,378,593	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-103,898	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00
		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part B Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	179	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,419	2.00
3.00	PPS payments	5,311	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.804	5.00
6.00	Line 2 times line 5	4,357	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	179	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	721	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)	721	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	721	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	542	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	179	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	5,311	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)	1,061	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)	4,429	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,429	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	4,429	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	4,429	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,429	40.00
40.01	Sequestration adjustment (see instructions)	89	40.01
41.00	Interim payments	4,165	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	175	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		27,013,531		8,362,895	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	03/09/2017	570,220	03/09/2017	15,698	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	04/14/2016	655,457		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)		-85,237		15,698	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)		26,928,294		8,378,593	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		600,067		103,898	6.02
7.00	Total Medicare program liability (see instructions)		26,328,227		8,274,695	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 8/15/2017 5:50 pm

Title XVIII | Subprovider - IRF | 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		6,087,822		4,165	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)		6,087,822		4,165	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		68,764		175	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,156,586		4,340	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: 14-0011	Period: From 04/01/2016 To 03/31/2017	Worksheet E-1 Part II Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	6,231	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	12,763	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,378	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	21,086	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	582,217,765	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,882,706	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	509,998	8.00
9.00	Sequestration adjustment amount (see instructions)	10,200	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	499,798	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	499,498	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	300	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2016 To 03/31/2017	Worksheet E-3 Part III Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	5,295,842	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0231	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	348,466	3.00
4.00	Outlier Payments	814,326	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	20.158904	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	6,458,634	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	6,458,634	17.00
18.00	Primary payer payments	12,206	18.00
19.00	Subtotal (line 17 less line 18).	6,446,428	19.00
20.00	Deductibles	28,420	20.00
21.00	Subtotal (line 19 minus line 20)	6,418,008	21.00
22.00	Coinsurance	144,242	22.00
23.00	Subtotal (line 21 minus line 22)	6,273,766	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13,023	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	8,465	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,412	26.00
27.00	Subtotal (sum of lines 23 and 25)	6,282,231	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	6,282,231	32.00
32.01	Sequestration adjustment (see instructions)	125,645	32.01
33.00	Interim payments	6,087,822	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	68,764	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	814,326	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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

Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G | Date/Time Prepared: 8/15/2017 5:50 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	576,007	0	44,757	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	62,726	0	0	0	3.00
4.00	Accounts receivable	152,479,320	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-116,912,539	0	0	0	6.00
7.00	Inventory	2,351,838	0	0	0	7.00
8.00	Prepaid expenses	339,075	0	0	0	8.00
9.00	Other current assets	241,591	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)	39,138,018	0	44,757	0	11.00
	FIXED ASSETS					
12.00	Land	4,119,371	0	0	0	12.00
13.00	Land improvements	4,580,925	0	0	0	13.00
14.00	Accumulated depreciation	-2,865,158	0	0	0	14.00
15.00	Buildings	80,096,086	0	0	0	15.00
16.00	Accumulated depreciation	-39,055,103	0	0	0	16.00
17.00	Leasehold improvements	26,804	0	0	0	17.00
18.00	Accumulated depreciation	-5,331	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	228,474	0	0	0	21.00
22.00	Accumulated depreciation	-182,992	0	0	0	22.00
23.00	Major movable equipment	32,645,202	0	0	0	23.00
24.00	Accumulated depreciation	-19,610,337	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	4,296,818	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	64,274,759	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	20,550	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,269,938	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,290,488	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	105,703,265	0	44,757	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,591,474	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,916,055	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	700,240	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	4,624,099	0	0	0	43.00
44.00	Other current liabilities	1,808,799	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,640,667	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	44,414,462	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	15,663	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	44,430,125	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	61,070,792	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	44,632,473				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			44,757		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	44,632,473	0	44,757	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	105,703,265	0	44,757	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G-1 | Date/Time Prepared: 8/15/2017 5:50 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		29,020,551		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,611,922				2.00
3.00	Total (sum of line 1 and line 2)		44,632,473		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	GRANTS	0		0		67,636	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)		44,632,473		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		25,791	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)		44,632,473		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	2,912		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)	2,912		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00	GRANTS		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)	67,636		0		10.00
11.00	Subtotal (line 3 plus line 10)	70,548		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)	25,791		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	44,757		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 8/15/2017 5:50 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,699,460		22,699,460	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	13,537,098		13,537,098	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)	36,236,558		36,236,558	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,940,212		2,940,212	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,940,212		2,940,212	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	39,176,770		39,176,770	17.00
18.00	Ancillary services	185,537,011	364,658,957	550,195,968	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				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)	224,713,781	364,658,957	589,372,738	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		118,055,160		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		118,055,160		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G-3 | Date/Time Prepared: 8/15/2017 5:50 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	589,372,738	1.00
2.00	Less contractual allowances and discounts on patients' accounts	428,152,629	2.00
3.00	Net patient revenues (line 1 minus line 2)	161,220,109	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	118,055,160	4.00
5.00	Net income from service to patients (line 3 minus line 4)	43,164,949	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,890,700	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	5,419	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	532,281	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	1,339	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	74,197	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	314,739	22.00
23.00	Governmental appropriations	1,568,086	23.00
24.00	MISCELLANEOUS	28	24.00
25.00	Total other income (sum of lines 6-24)	4,386,789	25.00
26.00	Total (line 5 plus line 25)	47,551,738	26.00
27.00	HOME OFFICE, CONTR, LOSS ON EQUIP	31,939,816	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	31,939,816	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,611,922	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0011	Period: From 04/01/2016 To 03/31/2017	Worksheet L Parts I-III Date/Time Prepared: 8/15/2017 5:50 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,846,085	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	16,897	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)	57.77	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,862,982	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