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: 14-1334

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

Worksheet S
Parts I-III
Date/Time Prepared:
8/8/2017 1:05 pm

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically filed cost report — Date: 8/8/2017 Time: 1:05 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 SAINT JOSEPH MEMORIAL HOSPITAL (14-1334) 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	-90,374	-350,444	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-92,149	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-182,523	-350,444	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 8/8/2017 1:04 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2 SOUTH HOSPITAL DRIVE	PO Box:			1.00
2.00	City: MURPHYSBORO	State: IL	Zip Code: 62966	County: JACKSON	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	SAINT JOSEPH MEMORIAL HOSPITAL	141334	16060	1	05/01/2004	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. JOSEPH HOSPITAL SWING BED	14Z334	16060		11/14/2013	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	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.	3	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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/8/2017 1:04 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.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/8/2017 1:04 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: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/8/2017 1:04 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.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		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)?	Y		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)	N		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.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	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:	1,023,750	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	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

		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 STREET	PO Box: 3988		142.00
143.00	City: CARBONDALE	State: IL	Zip Code: 62902-3988	143.00

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

		1.00	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)	N	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)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/8/2017 1:04 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: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 8/8/2017 1:04 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	08/03/2017	Y	08/03/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 8/8/2017 1:04 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	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	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.	SIH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200	LUANNE.WARREN@SIH.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 8/8/2017 1:04 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part IX Date/Time Prepared: 8/8/2017 1:04 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: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 8/8/2017 1:04 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	25	9,125	28,585.70	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)		25	9,125	28,585.70	0	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)		25	9,125	28,585.70	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 8/8/2017 1:04 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)	648	235	1,205			1.00
2.00	HMO and other (see instructions)	90	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,842	0	3,191			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)	2,490	235	4,396			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)	2,490	235	4,396	0.00	220.77	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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	220.77	27.00
28.00	Observation Bed Days		65	382			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: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 8/8/2017 1:04 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	228	77	423	1.00
2.00	HMO and other (see instructions)			33	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	228	77	423	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-10 | Date/Time Prepared: 8/8/2017 1:04 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)	0.239887	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,270,004	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	1,619,593	5.00
6.00	Medicaid charges	36,547,662	6.00
7.00	Medicaid cost (line 1 times line 6)	8,767,309	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)	877,712	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	58,672	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	877,712	19.00

		Uninsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	
20.00	Charity care charges for the entire facility (see instructions)	962,912	426,320	1,389,232	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	230,990	102,269	333,259	21.00
22.00	Partial payment by patients approved for charity care	2,574	7,704	10,278	22.00
23.00	Cost of charity care (line 21 minus line 22)	228,416	94,565	322,981	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)	4,539,399	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	1,076,348	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,463,051	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	830,741	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,153,722	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,031,434	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A | Date/Time Prepared: 8/8/2017 1:04 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		1,321,610	1,321,610	139,184	1,460,794	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,181,772	1,181,772	74,946	1,256,718	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144,841	4,211,188	4,356,029	0	4,356,029	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	30,501	42,614	73,115	0	73,115	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	465,874	27,387	493,261	0	493,261	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	894,009	2,025,151	2,919,160	0	2,919,160	5.04
6.00	00600	MAINTENANCE & REPAIRS	262,314	587,210	849,524	0	849,524	6.00
7.00	00700	OPERATION OF PLANT	152,390	8,019	160,409	0	160,409	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	222,403	222,403	0	222,403	8.00
9.00	00900	HOUSEKEEPING	246,342	44,939	291,281	-167	291,114	9.00
10.00	01000	DIETARY	328,098	115,648	443,746	-273,366	170,380	10.00
11.00	01100	CAFETERIA	0	0	0	269,668	269,668	11.00
13.00	01300	NURSING ADMINISTRATION	953,703	55,977	1,009,680	0	1,009,680	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,568	10,889	12,457	-99	12,358	14.00
15.00	01500	PHARMACY	523,003	6,408,344	6,931,347	-17,436	6,913,911	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	86,125	1,067	87,192	0	87,192	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	300,208	300,208	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,685,578	1,590,341	3,275,919	-19,748	3,256,171	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,137,756	3,060,198	4,197,954	-1,944,370	2,253,584	50.00
51.00	05100	RECOVERY ROOM	110,158	3,101	113,259	-753	112,506	51.00
53.00	05300	ANESTHESIOLOGY	201,879	360,081	561,960	-310,896	251,064	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	912,501	673,607	1,586,108	-38,297	1,547,811	54.00
60.00	06000	LABORATORY	635,013	1,512,827	2,147,840	-385	2,147,455	60.00
64.00	06400	INTRAVENOUS THERAPY	753,093	274,940	1,028,033	-9,833	1,018,200	64.00
65.00	06500	RESPIRATORY THERAPY	393,859	84,493	478,352	-40,252	438,100	65.00
65.01	03610	SLEEP LAB	836,711	321,246	1,157,957	0	1,157,957	65.01
65.02	03950	GERIATRIC PSYCH	0	412,658	412,658	0	412,658	65.02
66.00	06600	PHYSICAL THERAPY	665,451	342,819	1,008,270	-234	1,008,036	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	979,233	979,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	992,606	992,606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	133,475	133,475	73.00
76.97	07697	CARDIAC REHABILITATION	308,945	13,230	322,175	110	322,285	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	144,475	391,896	536,371	-4,169	532,202	90.00
91.00	09100	EMERGENCY	1,086,547	1,840,594	2,927,141	-15,295	2,911,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		456,024	456,024	-214,130	241,894	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,960,734	27,602,273	40,563,007	0	40,563,007	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	22,017	22,017	0	22,017	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		TOTAL (SUM OF LINES 118-199)	12,960,734	27,624,290	40,585,024	0	40,585,024	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A | Date/Time Prepared: 8/8/2017 1:04 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	-16,140	1,444,654	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	916,061	2,172,779	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-486,836	3,869,193	4.00
5.01	00550	DATA PROCESSING	2,003,286	2,003,286	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-2,298	70,817	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	713,531	1,206,792	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,571,531	4,490,691	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	849,524	6.00
7.00	00700	OPERATION OF PLANT	0	160,409	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	222,403	8.00
9.00	00900	HOUSEKEEPING	0	291,114	9.00
10.00	01000	DIETARY	0	170,380	10.00
11.00	01100	CAFETERIA	-87,360	182,308	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,009,680	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,358	14.00
15.00	01500	PHARMACY	0	6,913,911	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,614	72,578	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-300,208	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,179,729	2,076,442	30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,253,584	50.00
51.00	05100	RECOVERY ROOM	0	112,506	51.00
53.00	05300	ANESTHESIOLOGY	0	251,064	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-43,172	1,504,639	54.00
60.00	06000	LABORATORY	-21,636	2,125,819	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,018,200	64.00
65.00	06500	RESPIRATORY THERAPY	-27,043	411,057	65.00
65.01	03610	SLEEP LAB	-7,037	1,150,920	65.01
65.02	03950	GERIATRIC PSYCH	0	412,658	65.02
66.00	06600	PHYSICAL THERAPY	-555	1,007,481	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	979,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	992,606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	133,475	73.00
76.97	07697	CARDIAC REHABILITATION	0	322,285	76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	532,202	90.00
91.00	09100	EMERGENCY	-1,568,985	1,342,861	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-241,894	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,206,902	41,769,909	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-7,079	14,938	192.00
192.01	19201	UNUSED SPACE	0	0	192.01
200.00		TOTAL (SUM OF LINES 118-199)	1,199,823	41,784,847	200.00

COST CENTERS USED IN COST REPORT	Provider CCN: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet Non-CMS W Date/Time Prepared: 8/8/2017 1:04 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
7.00	OPERATION OF PLANT	00700		7.00
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
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
	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
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
65.01	SLEEP LAB	03610	SLEEP LAB	65.01
65.02	GERIATRIC PSYCH	03950		65.02
66.00	PHYSICAL THERAPY	06600		66.00
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	UNUSED SPACE	19201		192.01
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-6 | Date/Time Prepared: 8/8/2017 1:04 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DIETARY RECLASS				
1.00	CAFETERIA	11.00	201,063	70,871	1.00
	TOTALS		201,063	70,871	
	B - MEDICAL SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,971,839	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
	TOTALS		0	1,971,839	
	C - IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	85,609	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
	TOTALS		0	85,609	
	D - INTEREST RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	139,184	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	74,946	2.00
	TOTALS		0	214,130	
	E - IMPLANTABLE SUPPLIES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	992,606	1.00
	TOTALS		0	992,606	
	F - CONTRAST RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	47,866	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	47,866	
	G - CRNA RECLASS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	300,208	1.00
	TOTALS		0	300,208	
	H - CVP MED DIRECTOR RECLASS				
1.00	CARDIAC REHABILITATION	76.97	0	110	1.00
	TOTALS		0	110	
500.00	Grand Total: Increases		201,063	3,683,239	500.00

RECLASSIFICATIONS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-6 | Date/Time Prepared: 8/8/2017 1:04 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY RECLASS						
1.00	DIETARY	10.00	201,063	70,871	0		1.00
	TOTALS		201,063	70,871			
	B - MEDICAL SUPPLY RECLASS						
1.00	OPERATING ROOM	50.00	0	1,916,850	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	8,539	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	32,798	0		3.00
4.00	INTRAVENOUS THERAPY	64.00	0	1,756	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	234	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	99	0		6.00
7.00	LABORATORY	60.00	0	385	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,343	0		8.00
9.00	EMERGENCY	91.00	0	1,197	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	122	0		10.00
11.00	CLINIC	90.00	0	4,166	0		11.00
12.00	PHARMACY	15.00	0	183	0		12.00
13.00	HOUSEKEEPING	9.00	0	167	0		13.00
	TOTALS		0	1,971,839			
	C - IV SOLUTIONS						
1.00	DIETARY	10.00	0	1,432	0		1.00
2.00	CAFETERIA	11.00	0	2,266	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	19,626	0		3.00
4.00	OPERATING ROOM	50.00	0	19,939	0		4.00
5.00	RECOVERY ROOM	51.00	0	753	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	2,149	0		6.00
7.00	EMERGENCY	91.00	0	14,098	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	8,077	0		8.00
9.00	PHARMACY	15.00	0	17,253	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13	0		10.00
11.00	CLINIC	90.00	0	3	0		11.00
	TOTALS		0	85,609			
	D - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	214,130	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	214,130			
	E - IMPLANTABLE SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	992,606	0		1.00
	TOTALS		0	992,606			
	F - CONTRAST RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,941	0		1.00
2.00	OPERATING ROOM	50.00	0	7,581	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	7,344	0		3.00
	TOTALS		0	47,866			
	G - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	300,208	0		1.00
	TOTALS		0	300,208			
	H - CVP MED DIRECTOR RECLASS						
1.00	RESPIRATORY THERAPY	65.00	0	110	0		1.00
	TOTALS		0	110			
500.00	Grand Total: Decreases		201,063	3,683,239			500.00

RECLASSIFICATIONS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 8/8/2017 1:04 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - DIETARY RECLASS								
1.00	CAFETERIA	11.00	201,063	70,871	DIETARY	10.00	201,063	70,871	1.00
	TOTALS		201,063	70,871	TOTALS		201,063	70,871	
	B - MEDICAL SUPPLY RECLASS								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,971,839	OPERATING ROOM	50.00	0	1,916,850	1.00
2.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	8,539	2.00
3.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	32,798	3.00
4.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	1,756	4.00
5.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	234	5.00
6.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	99	6.00
7.00		0.00	0	0	LABORATORY	60.00	0	385	7.00
8.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	5,343	8.00
9.00		0.00	0	0	EMERGENCY	91.00	0	1,197	9.00
10.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	122	10.00
11.00		0.00	0	0	CLINIC	90.00	0	4,166	11.00
12.00		0.00	0	0	PHARMACY	15.00	0	183	12.00
13.00		0.00	0	0	HOUSEKEEPING	9.00	0	167	13.00
	TOTALS		0	1,971,839	TOTALS		0	1,971,839	
	C - IV SOLUTIONS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	85,609	DIETARY	10.00	0	1,432	1.00
2.00		0.00	0	0	CAFETERIA	11.00	0	2,266	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	19,626	3.00
4.00		0.00	0	0	OPERATING ROOM	50.00	0	19,939	4.00
5.00		0.00	0	0	RECOVERY ROOM	51.00	0	753	5.00
6.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	2,149	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	14,098	7.00
8.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	8,077	8.00
9.00		0.00	0	0	PHARMACY	15.00	0	17,253	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	13	10.00
11.00		0.00	0	0	CLINIC	90.00	0	3	11.00
	TOTALS		0	85,609	TOTALS		0	85,609	
	D - INTEREST RECLASS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	139,184	INTEREST EXPENSE	113.00	0	214,130	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	74,946		0.00	0	0	2.00
	TOTALS		0	214,130	TOTALS		0	214,130	
	E - IMPLANTABLE SUPPLIES RECLASS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	992,606	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	992,606	1.00
	TOTALS		0	992,606	TOTALS		0	992,606	
	F - CONTRAST RECLASS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	47,866	RADIOLOGY-DIAGNOSTIC	54.00	0	32,941	1.00
2.00		0.00	0	0	OPERATING ROOM	50.00	0	7,581	2.00
3.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	7,344	3.00
	TOTALS		0	47,866	TOTALS		0	47,866	
	G - CRNA RECLASS								
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	300,208	ANESTHESIOLOGY	53.00	0	300,208	1.00
	TOTALS		0	300,208	TOTALS		0	300,208	
	H - CVP MED DIRECTOR RECLASS								
1.00	CARDIAC REHABILITATION	76.97	0	110	RESPIRATORY THERAPY	65.00	0	110	1.00
	TOTALS		0	110	TOTALS		0	110	
500.00	Grand Total: Increases		201,063	3,683,239	Grand Total: Decreases		201,063	3,683,239	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part I Date/Time Prepared: 8/8/2017 1:04 pm

		Beginning Balances	Acquisitions Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	171,136	0	0	0	0	1.00
2.00	Land Improvements	1,109,977	34,282	0	34,282	6,465	2.00
3.00	Buildings and Fixtures	24,372,448	518,336	0	518,336	6,824	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,820,806	2,587,923	0	2,587,923	2,468,468	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,474,367	3,140,541	0	3,140,541	2,481,757	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,474,367	3,140,541	0	3,140,541	2,481,757	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	171,136	0	1.00
2.00	Land Improvements	1,137,794	0	2.00
3.00	Buildings and Fixtures	24,883,960	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,940,261	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,133,151	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	40,133,151	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 8/8/2017 1:04 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	1,321,610	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,181,772	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,503,382	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	1,321,610	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,181,772	2.00
3.00	Total (sum of lines 1-2)	0	2,503,382	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 8/8/2017 1:04 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	24,883,959	0	24,883,959	0.620035	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,249,191	0	15,249,191	0.379965	0	2.00
3.00	Total (sum of lines 1-2)	40,133,150	0	40,133,150	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,444,654	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,172,779	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,617,433	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,444,654	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,172,779	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3,617,433	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8 | Date/Time Prepared: 8/8/2017 1:04 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	-2,775,757			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	7,493,321			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-87,360	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	-14,614	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	-300,208	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	PURCHASE DISCOUNTS	B	-2,298	PURCHASING RECEIVING AND STORES	5.02	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8 | Date/Time Prepared: 8/8/2017 1:04 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	EMPLOYEE OUTPATIENT INSURANCE PAYMEN	B	-1,478,358	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	LOBBYING EXPENSES	A	-9,864	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03	UNRESTRICTED INTEREST REVENUE	B	-416,500	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.03
33.04	LEASEHOLD REVENUE	B	-56,123	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	XRAY FILM REVENUE	B	-490	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	NONALLOWABLE INTEREST EXPENSE	A	-241,894	INTEREST EXPENSE	113.00	0	33.06
33.07	REAL ESTATE TAXES	A	-7,079	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.07
33.08	MEDICAID PROVIDER TAX	A	-891,037	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	CABLE TV	A	-1,774	SLEEP LAB	65.01	0	33.09
33.10	CABLE TV	A	-555	PHYSICAL THERAPY	66.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-275	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12	REAL ESTATE TAXES	A	-5,263	SLEEP LAB	65.01	0	33.12
33.13	SHAWNEE BUILDING DEPR.	A	-4,049	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,199,823				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: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8-1 Date/Time Prepared: 8/8/2017 1:04 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	44,032	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	916,061	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	991,522	0	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	2,003,286	0	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	713,531	0	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	2,889,207	0	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	RENT	34,219	76,901	4.03
4.04	60.00	LABORATORY	RENT	17,347	38,983	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,609,205	115,884	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B	SIHS	100.00	HOME OFFICE	100.00	6.00
7.00	B	SIHE	100.00	RELATED ORG	100.00	7.00
8.00	B	HSSI	100.00	RELATED ORG	100.00	8.00
9.00	B	SIMS	100.00	RELATED ORG	100.00	9.00
10.00	B	SIH CAYNMAN	100.00	RELATED ORG	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet A-8-1 Date/Time Prepared: 8/8/2017 1:04 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	44,032	9	1.00
2.00	916,061	9	2.00
3.00	991,522	0	3.00
4.00	2,003,286	0	4.00
4.01	713,531	0	4.01
4.02	2,889,207	0	4.02
4.03	-42,682	0	4.03
4.04	-21,636	0	4.04
5.00	7,493,321		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.

	Type of Business	
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: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 8/8/2017 1:04 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	91.00	DR. A	1,568,985	1,568,985	0	0	0	1.00
2.00	60.00	DR. B	141,285	0	141,285	0	0	2.00
3.00	76.97	DR. C	2,145	0	2,145	0	0	3.00
4.00	65.01	DR. D	26,400	0	26,400	0	0	4.00
5.00	65.00	DR. E	27,043	27,043	0	0	0	5.00
6.00	30.00	DR. F	1,179,729	1,179,729	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,945,587	2,775,757	169,830		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	DR. A	0	0	0	0	0	1.00
2.00	60.00	DR. B	0	0	0	0	0	2.00
3.00	76.97	DR. C	0	0	0	0	0	3.00
4.00	65.01	DR. D	0	0	0	0	0	4.00
5.00	65.00	DR. E	0	0	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	91.00	DR. A	0	0	0	1,568,985	1.00
2.00	60.00	DR. B	0	0	0	0	2.00
3.00	76.97	DR. C	0	0	0	0	3.00
4.00	65.01	DR. D	0	0	0	0	4.00
5.00	65.00	DR. E	0	0	0	27,043	5.00
6.00	30.00	DR. F	0	0	0	1,179,729	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	2,775,757	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	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	1,444,654	1,444,654				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,172,779		2,172,779			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,869,193	12,158	18,286	3,899,637		4.00
5.01	00550	DATA PROCESSING	2,003,286	6,703	10,081	0	2,020,070	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	70,817	6,522	9,810	9,281	6,871	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,206,792	20,063	30,175	141,757	82,452	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	4,490,691	287,390	432,235	272,030	171,775	5.04
6.00	00600	MAINTENANCE & REPAIRS	849,524	60,324	90,728	79,817	116,807	6.00
7.00	00700	OPERATION OF PLANT	160,409	86,173	129,605	46,369	6,871	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	222,403	10,129	15,234	0	0	8.00
9.00	00900	HOUSEKEEPING	291,114	8,281	12,454	74,957	6,871	9.00
10.00	01000	DIETARY	170,380	71,520	107,568	38,654	20,613	10.00
11.00	01100	CAFETERIA	182,308	7,063	10,623	61,180	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,009,680	31,620	47,557	290,194	54,968	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,358	7,018	10,556	477	0	14.00
15.00	01500	PHARMACY	6,913,911	22,873	34,402	159,140	34,355	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	72,578	70,033	105,330	26,206	34,355	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,076,442	159,377	239,705	512,893	247,356	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,253,584	191,658	288,256	346,198	343,546	50.00
51.00	05100	RECOVERY ROOM	112,506	21,355	32,119	33,519	27,484	51.00
53.00	05300	ANESTHESIOLOGY	251,064	1,172	1,763	61,428	20,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,504,639	60,595	91,135	277,657	116,807	54.00
60.00	06000	LABORATORY	2,125,819	35,617	53,569	193,222	116,807	60.00
64.00	06400	INTRAVENOUS THERAPY	1,018,200	14,307	21,518	229,152	75,581	64.00
65.00	06500	RESPIRATORY THERAPY	411,057	10,099	15,189	119,844	61,839	65.00
65.01	03610	SLEEP LAB	1,150,920	63,676	95,769	254,595	116,807	65.01
65.02	03950	GERIATRIC PSYCH	412,658	18,470	27,779	0	34,355	65.02
66.00	06600	PHYSICAL THERAPY	1,007,481	9,363	14,082	202,484	123,678	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	979,233	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	992,606	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	133,475	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	322,285	28,779	43,285	94,006	27,484	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	532,202	40,652	61,141	43,961	82,452	90.00
91.00	09100	EMERGENCY	1,342,861	61,737	92,853	330,616	89,323	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)	41,769,909	1,424,727	2,142,807	3,899,637	2,020,070	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,567	9,878	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,938	13,360	20,094	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	41,784,847	1,444,654	2,172,779	3,899,637	2,020,070	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I Date/Time Prepared: 8/8/2017 1:04 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	103,301					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,106	1,482,345				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	5,654,121	5,654,121		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,197,200	187,351	1,384,551	6.00
7.00	00700	OPERATION OF PLANT	0	0	429,427	67,201	113,468	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	247,766	38,773	13,338	8.00
9.00	00900	HOUSEKEEPING	19	0	393,696	61,610	10,904	9.00
10.00	01000	DIETARY	43	0	408,778	63,970	94,174	10.00
11.00	01100	CAFETERIA	69	0	261,243	40,882	9,301	11.00
13.00	01300	NURSING ADMINISTRATION	4	0	1,434,023	224,412	41,635	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50	0	30,459	4,767	9,241	14.00
15.00	01500	PHARMACY	1,563	0	7,166,244	1,121,440	30,118	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	308,502	48,278	92,215	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,831	24,333	3,271,937	512,029	209,858	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,114	208,948	3,673,304	574,839	252,364	50.00
51.00	05100	RECOVERY ROOM	185	56,912	284,080	44,456	28,120	51.00
53.00	05300	ANESTHESIOLOGY	2,326	33,162	371,528	58,141	1,544	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,173	320,982	2,375,988	371,821	79,788	54.00
60.00	06000	LABORATORY	4,491	264,218	2,793,743	437,196	46,899	60.00
64.00	06400	INTRAVENOUS THERAPY	20,838	28,856	1,408,452	220,410	18,839	64.00
65.00	06500	RESPIRATORY THERAPY	810	28,529	647,367	101,307	13,298	65.00
65.01	03610	SLEEP LAB	810	96,568	1,779,145	278,420	83,844	65.01
65.02	03950	GERIATRIC PSYCH	0	5,169	498,431	78,000	24,320	65.02
66.00	06600	PHYSICAL THERAPY	647	42,765	1,400,500	219,166	12,328	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,508	1,009,741	158,015	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,906	1,020,512	159,701	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	190,898	324,373	50,761	0	73.00
76.97	07697	CARDIAC REHABILITATION	199	11,675	527,713	82,582	37,895	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,310	22,564	784,282	122,733	53,528	90.00
91.00	09100	EMERGENCY	11,713	88,352	2,017,455	315,714	81,292	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)	103,301	1,482,345	41,720,010	5,643,975	1,358,311	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,445	2,573	8,648	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	48,392	7,573	17,592	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	103,301	1,482,345	41,784,847	5,654,121	1,384,551	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	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
7.00	00700	OPERATION OF PLANT	610,096					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,402	306,279				8.00
9.00	00900	HOUSEKEEPING	5,233	135	471,578			9.00
10.00	01000	DIETARY	45,202	119	1,050	613,293		10.00
11.00	01100	CAFETERIA	4,464	0	5,252	0	321,142	11.00
13.00	01300	NURSING ADMINISTRATION	19,984	0	0	0	25,302	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,436	0	0	0	0	14.00
15.00	01500	PHARMACY	14,456	0	2,101	0	11,678	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,261	0	525	0	5,839	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	100,728	105,254	200,206	613,293	52,550	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	121,130	63,177	76,335	0	38,926	50.00
51.00	05100	RECOVERY ROOM	13,497	21,739	2,101	0	1,946	51.00
53.00	05300	ANESTHESIOLOGY	741	0	1,663	0	5,839	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,297	12,555	21,010	0	29,195	54.00
60.00	06000	LABORATORY	22,511	0	16,808	0	25,302	60.00
64.00	06400	INTRAVENOUS THERAPY	9,042	0	15,757	0	23,356	64.00
65.00	06500	RESPIRATORY THERAPY	6,383	334	3,151	0	11,678	65.00
65.01	03610	SLEEP LAB	40,244	1,465	25,824	0	27,248	65.01
65.02	03950	GERIATRIC PSYCH	11,673	0	5,252	0	0	65.02
66.00	06600	PHYSICAL THERAPY	5,917	0	0	0	19,463	66.00
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	18,189	973	10,505	0	9,732	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,693	11,979	42,019	0	3,893	90.00
91.00	09100	EMERGENCY	39,018	88,549	42,019	0	29,195	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)	597,501	306,279	471,578	613,293	321,142	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,151	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,444	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	610,096	306,279	471,578	613,293	321,142	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,745,356					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	48,903				14.00
15.00	01500	PHARMACY	144,437	5	8,490,479			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	499,620		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	673,113	3	26,501	76,278	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	498,303	47,543	32,517	150,648	0	50.00
51.00	05100	RECOVERY ROOM	36,930	0	1,015	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	212	15,781	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	133	18	49,581	0	54.00
60.00	06000	LABORATORY	0	10	0	34,325	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	44	10,940	49,581	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	814	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	15,256	0	65.01
65.02	03950	GERIATRIC PSYCH	0	0	0	3,814	0	65.02
66.00	06600	PHYSICAL THERAPY	0	6	1,103	7,628	0	66.00
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	8,380,011	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	103	3,426	22,883	0	90.00
91.00	09100	EMERGENCY	392,573	30	19,167	89,626	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)	1,745,356	48,903	8,490,479	499,620	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	1,745,356	48,903	8,490,479	499,620	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,841,750	0	5,841,750		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,529,086	0	5,529,086		50.00
51.00	05100	RECOVERY ROOM	433,884	0	433,884		51.00
53.00	05300	ANESTHESIOLOGY	455,449	0	455,449		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,978,386	0	2,978,386		54.00
60.00	06000	LABORATORY	3,376,794	0	3,376,794		60.00
64.00	06400	INTRAVENOUS THERAPY	1,756,421	0	1,756,421		64.00
65.00	06500	RESPIRATORY THERAPY	784,332	0	784,332		65.00
65.01	03610	SLEEP LAB	2,251,446	0	2,251,446		65.01
65.02	03950	GERIATRIC PSYCH	621,490	0	621,490		65.02
66.00	06600	PHYSICAL THERAPY	1,666,111	0	1,666,111		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,167,756	0	1,167,756		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,180,213	0	1,180,213		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,755,145	0	8,755,145		73.00
76.97	07697	CARDIAC REHABILITATION	687,589	0	687,589		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,070,539	0	1,070,539		90.00
91.00	09100	EMERGENCY	3,114,638	0	3,114,638		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)	41,671,029	0	41,671,029		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,817	0	31,817		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82,001	0	82,001		192.00
192.01	19201	UNUSED SPACE	0	0	0		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	41,784,847	0	41,784,847		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet Non-CMS W Date/Time Prepared: 8/8/2017 1:04 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	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	2	GROSS SALARIES	4.00
5.01	DATA PROCESSING	3	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	4	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	5	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	6	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	7	HOURS OF SERVICE	9.00
10.00	DIETARY	8	MEALS SERVED	10.00
11.00	CAFETERIA	9	NUMBER OF FTES	11.00
13.00	NURSING ADMINISTRATION	10	DIRECT NURSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
15.00	PHARMACY	12	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	13	TIME SPENT	16.00
19.00	NONPHYSICIAN ANESTHETISTS	15	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	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	12,158	18,286	30,444	30,444	4.00
5.01	00550	DATA PROCESSING	0	6,703	10,081	16,784	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	6,522	9,810	16,332	72	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	20,063	30,175	50,238	1,106	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	287,390	432,235	719,625	2,123	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	60,324	90,728	151,052	623	6.00
7.00	00700	OPERATION OF PLANT	0	86,173	129,605	215,778	362	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,129	15,234	25,363	0	8.00
9.00	00900	HOUSEKEEPING	0	8,281	12,454	20,735	585	9.00
10.00	01000	DIETARY	0	71,520	107,568	179,088	302	10.00
11.00	01100	CAFETERIA	0	7,063	10,623	17,686	478	11.00
13.00	01300	NURSING ADMINISTRATION	0	31,620	47,557	79,177	2,265	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,018	10,556	17,574	4	14.00
15.00	01500	PHARMACY	0	22,873	34,402	57,275	1,242	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	70,033	105,330	175,363	205	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	159,377	239,705	399,082	4,010	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	191,658	288,256	479,914	2,702	50.00
51.00	05100	RECOVERY ROOM	0	21,355	32,119	53,474	262	51.00
53.00	05300	ANESTHESIOLOGY	0	1,172	1,763	2,935	479	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	60,595	91,135	151,730	2,167	54.00
60.00	06000	LABORATORY	0	35,617	53,569	89,186	1,508	60.00
64.00	06400	INTRAVENOUS THERAPY	0	14,307	21,518	35,825	1,789	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,099	15,189	25,288	935	65.00
65.01	03610	SLEEP LAB	0	63,676	95,769	159,445	1,987	65.01
65.02	03950	GERIATRIC PSYCH	0	18,470	27,779	46,249	0	65.02
66.00	06600	PHYSICAL THERAPY	0	9,363	14,082	23,445	1,580	66.00
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	28,779	43,285	72,064	734	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	40,652	61,141	101,793	343	90.00
91.00	09100	EMERGENCY	0	61,737	92,853	154,590	2,581	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	1,424,727	2,142,807	3,567,534	30,444	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,567	9,878	16,445	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,360	20,094	33,454	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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	1,444,654	2,172,779	3,617,433	30,444	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II Date/Time Prepared: 8/8/2017 1:04 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	16,784					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	57	16,461				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	685	176	52,205			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,427	0	0	723,175		5.04
6.00	00600	MAINTENANCE & REPAIRS	971	0	0	23,963	176,609	6.00
7.00	00700	OPERATION OF PLANT	57	0	0	8,595	14,474	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,959	1,701	8.00
9.00	00900	HOUSEKEEPING	57	3	0	7,880	1,391	9.00
10.00	01000	DIETARY	171	7	0	8,182	12,013	10.00
11.00	01100	CAFETERIA	0	11	0	5,229	1,186	11.00
13.00	01300	NURSING ADMINISTRATION	457	1	0	28,703	5,311	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8	0	610	1,179	14.00
15.00	01500	PHARMACY	285	249	0	143,421	3,842	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	285	0	0	6,175	11,763	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,055	1,885	858	65,491	26,769	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,855	6,551	7,370	73,525	32,190	50.00
51.00	05100	RECOVERY ROOM	228	30	2,007	5,686	3,587	51.00
53.00	05300	ANESTHESIOLOGY	171	371	1,170	7,437	197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	971	665	11,244	47,558	10,177	54.00
60.00	06000	LABORATORY	971	716	9,319	55,920	5,982	60.00
64.00	06400	INTRAVENOUS THERAPY	628	3,320	1,018	28,192	2,403	64.00
65.00	06500	RESPIRATORY THERAPY	514	129	1,006	12,958	1,696	65.00
65.01	03610	SLEEP LAB	971	129	3,406	35,611	10,695	65.01
65.02	03950	GERIATRIC PSYCH	285	0	182	9,977	3,102	65.02
66.00	06600	PHYSICAL THERAPY	1,028	103	1,508	28,032	1,573	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,076	20,211	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	984	20,427	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,733	6,493	0	73.00
76.97	07697	CARDIAC REHABILITATION	228	32	412	10,563	4,834	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	685	209	796	15,698	6,828	90.00
91.00	09100	EMERGENCY	742	1,866	3,116	40,381	10,369	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)	16,784	16,461	52,205	721,877	173,262	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	329	1,103	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	969	2,244	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	16,784	16,461	52,205	723,175	176,609	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II | Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	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
7.00	00700	OPERATION OF PLANT	239,266					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,511	34,534				8.00
9.00	00900	HOUSEKEEPING	2,052	15	32,718			9.00
10.00	01000	DIETARY	17,727	13	73	217,576		10.00
11.00	01100	CAFETERIA	1,751	0	364	0	26,705	11.00
13.00	01300	NURSING ADMINISTRATION	7,837	0	0	0	2,104	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,740	0	0	0	0	14.00
15.00	01500	PHARMACY	5,669	0	146	0	971	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,358	0	36	0	486	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,503	11,868	13,891	217,576	4,369	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	47,506	7,123	5,296	0	3,237	50.00
51.00	05100	RECOVERY ROOM	5,293	2,451	146	0	162	51.00
53.00	05300	ANESTHESIOLOGY	291	0	115	0	486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,019	1,416	1,458	0	2,428	54.00
60.00	06000	LABORATORY	8,828	0	1,166	0	2,104	60.00
64.00	06400	INTRAVENOUS THERAPY	3,546	0	1,093	0	1,942	64.00
65.00	06500	RESPIRATORY THERAPY	2,503	38	219	0	971	65.00
65.01	03610	SLEEP LAB	15,783	165	1,792	0	2,266	65.01
65.02	03950	GERIATRIC PSYCH	4,578	0	364	0	0	65.02
66.00	06600	PHYSICAL THERAPY	2,321	0	0	0	1,618	66.00
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	7,133	110	729	0	809	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,076	1,351	2,915	0	324	90.00
91.00	09100	EMERGENCY	15,302	9,984	2,915	0	2,428	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)	234,327	34,534	32,718	217,576	26,705	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,628	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,311	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	239,266	34,534	32,718	217,576	26,705	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	125,855					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,115				14.00
15.00	01500	PHARMACY	10,415	2	223,517			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	211,671		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,537	1	698	32,316		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,932	20,529	856	63,823		50.00
51.00	05100	RECOVERY ROOM	2,663	0	27	0		51.00
53.00	05300	ANESTHESIOLOGY	0	91	415	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57	0	21,006		54.00
60.00	06000	LABORATORY	0	4	0	14,542		60.00
64.00	06400	INTRAVENOUS THERAPY	0	19	288	21,006		64.00
65.00	06500	RESPIRATORY THERAPY	0	351	0	0		65.00
65.01	03610	SLEEP LAB	0	0	0	6,463		65.01
65.02	03950	GERIATRIC PSYCH	0	0	0	1,616		65.02
66.00	06600	PHYSICAL THERAPY	0	3	29	3,232		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	220,609	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	45	90	9,695		90.00
91.00	09100	EMERGENCY	28,308	13	505	37,972		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)	125,855	21,115	223,517	211,671	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	UNUSED SPACE	0	0	0	0		192.01
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)	125,855	21,115	223,517	211,671	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	868,909	0	868,909		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	789,409	0	789,409		50.00
51.00	05100	RECOVERY ROOM	76,016	0	76,016		51.00
53.00	05300	ANESTHESIOLOGY	14,158	0	14,158		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	265,896	0	265,896		54.00
60.00	06000	LABORATORY	190,246	0	190,246		60.00
64.00	06400	INTRAVENOUS THERAPY	101,069	0	101,069		64.00
65.00	06500	RESPIRATORY THERAPY	46,608	0	46,608		65.00
65.01	03610	SLEEP LAB	238,713	0	238,713		65.01
65.02	03950	GERIATRIC PSYCH	66,353	0	66,353		65.02
66.00	06600	PHYSICAL THERAPY	64,472	0	64,472		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,287	0	21,287		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,411	0	21,411		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,835	0	233,835		73.00
76.97	07697	CARDIAC REHABILITATION	97,648	0	97,648		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	150,848	0	150,848		90.00
91.00	09100	EMERGENCY	311,072	0	311,072		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)	3,557,950	0	3,557,950		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,505	0	19,505		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,978	0	39,978		192.00
192.01	19201	UNUSED SPACE	0	0	0		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	3,617,433	0	3,617,433		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	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	96,128					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		96,128				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	809	809	12,815,893			4.00
5.01	00550	DATA PROCESSING	446	446	0	294		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	434	434	30,501	1	1,204,216	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,335	1,335	465,874	12	12,888	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	19,123	19,123	894,009	25	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	4,014	4,014	262,314	17	0	6.00
7.00	00700	OPERATION OF PLANT	5,734	5,734	152,390	1	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	674	674	0	0	0	8.00
9.00	00900	HOUSEKEEPING	551	551	246,342	1	217	9.00
10.00	01000	DIETARY	4,759	4,759	127,035	3	507	10.00
11.00	01100	CAFETERIA	470	470	201,063	0	803	11.00
13.00	01300	NURSING ADMINISTRATION	2,104	2,104	953,703	8	47	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	467	467	1,568	0	579	14.00
15.00	01500	PHARMACY	1,522	1,522	523,003	5	18,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,660	4,660	86,125	5	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,605	10,605	1,685,578	36	137,912	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,753	12,753	1,137,756	50	479,292	50.00
51.00	05100	RECOVERY ROOM	1,421	1,421	110,158	4	2,161	51.00
53.00	05300	ANESTHESIOLOGY	78	78	201,879	3	27,115	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,032	4,032	912,501	17	48,645	54.00
60.00	06000	LABORATORY	2,370	2,370	635,013	17	52,354	60.00
64.00	06400	INTRAVENOUS THERAPY	952	952	753,093	11	242,913	64.00
65.00	06500	RESPIRATORY THERAPY	672	672	393,859	9	9,441	65.00
65.01	03610	SLEEP LAB	4,237	4,237	836,711	17	9,438	65.01
65.02	03950	GERIATRIC PSYCH	1,229	1,229	0	5	0	65.02
66.00	06600	PHYSICAL THERAPY	623	623	665,451	18	7,540	66.00
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	1,915	1,915	308,945	4	2,324	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,705	2,705	144,475	12	15,271	90.00
91.00	09100	EMERGENCY	4,108	4,108	1,086,547	13	136,545	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)	94,802	94,802	12,815,893	294	1,204,216	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	437	437	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	889	889	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,444,654	2,172,779	3,899,637	2,020,070	103,301	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.028441	22.602977	0.304281	6,870.986395	0.085783	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			30,444	16,784	16,461	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002375	57.088435	0.013669	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5A.04	5.04	6.00	7.00	
		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	177,230,730					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-5,654,121	36,130,726			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,197,200	69,967		6.00
7.00	00700	OPERATION OF PLANT	0	0	429,427	5,734	64,233	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	247,766	674	674	8.00
9.00	00900	HOUSEKEEPING	0	0	393,696	551	551	9.00
10.00	01000	DIETARY	0	0	408,778	4,759	4,759	10.00
11.00	01100	CAFETERIA	0	0	261,243	470	470	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,434,023	2,104	2,104	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	30,459	467	467	14.00
15.00	01500	PHARMACY	0	0	7,166,244	1,522	1,522	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	308,502	4,660	4,660	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,909,210	0	3,271,937	10,605	10,605	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,981,768	0	3,673,304	12,753	12,753	50.00
51.00	05100	RECOVERY ROOM	6,804,368	0	284,080	1,421	1,421	51.00
53.00	05300	ANESTHESIOLOGY	3,964,849	0	371,528	78	78	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,378,297	0	2,375,988	4,032	4,032	54.00
60.00	06000	LABORATORY	31,589,883	0	2,793,743	2,370	2,370	60.00
64.00	06400	INTRAVENOUS THERAPY	3,450,030	0	1,408,452	952	952	64.00
65.00	06500	RESPIRATORY THERAPY	3,410,978	0	647,367	672	672	65.00
65.01	03610	SLEEP LAB	11,545,693	0	1,779,145	4,237	4,237	65.01
65.02	03950	GERIATRIC PSYCH	618,008	0	498,431	1,229	1,229	65.02
66.00	06600	PHYSICAL THERAPY	5,113,042	0	1,400,500	623	623	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,647,522	0	1,009,741	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,336,399	0	1,020,512	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,823,780	0	324,373	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,395,842	0	527,713	1,915	1,915	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,697,747	0	784,282	2,705	2,705	90.00
91.00	09100	EMERGENCY	10,563,314	0	2,017,455	4,108	4,108	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)	177,230,730	-5,654,121	36,065,889	68,641	62,907	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,445	437	437	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	48,392	889	889	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,482,345		5,654,121	1,384,551	610,096	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008364		0.156491	19.788629	9.498171	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,205		723,175	176,609	239,266	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000295		0.020016	2.524176	3.724970	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	
			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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,136					8.00
9.00	00900	HOUSEKEEPING	34	5,387				9.00
10.00	01000	DIETARY	30	12	17,452			10.00
11.00	01100	CAFETERIA	0	60	0	165		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	13	143,484	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	24	0	6	11,874	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6	0	3	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,508	2,287	17,452	27	55,336	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,911	872	0	20	40,965	50.00
51.00	05100	RECOVERY ROOM	5,475	24	0	1	3,036	51.00
53.00	05300	ANESTHESIOLOGY	0	19	0	3	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,162	240	0	15	0	54.00
60.00	06000	LABORATORY	0	192	0	13	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	180	0	12	0	64.00
65.00	06500	RESPIRATORY THERAPY	84	36	0	6	0	65.00
65.01	03610	SLEEP LAB	369	295	0	14	0	65.01
65.02	03950	GERIATRIC PSYCH	0	60	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	10	0	66.00
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	245	120	0	5	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,017	480	0	2	0	90.00
91.00	09100	EMERGENCY	22,301	480	0	15	32,273	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)	77,136	5,387	17,452	165	143,484	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	306,279	471,578	613,293	321,142	1,745,356	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.970636	87.540004	35.141703	1,946.315152	12.164116	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	34,534	32,718	217,576	26,705	125,855	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.447703	6.073510	12.467110	161.848485	0.877136	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/8/2017 1:04 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,971,573					14.00
15.00	01500	PHARMACY	183	6,297,429				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	262			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	122	19,656	40	0		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,916,850	24,118	79	0		50.00
51.00	05100	RECOVERY ROOM	0	753	0	0		51.00
53.00	05300	ANESTHESIOLOGY	8,539	11,705	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,343	13	26	0		54.00
60.00	06000	LABORATORY	385	0	18	0		60.00
64.00	06400	INTRAVENOUS THERAPY	1,756	8,114	26	0		64.00
65.00	06500	RESPIRATORY THERAPY	32,798	0	0	0		65.00
65.01	03610	SLEEP LAB	0	0	8	0		65.01
65.02	03950	GERIATRIC PSYCH	0	0	2	0		65.02
66.00	06600	PHYSICAL THERAPY	234	818	4	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,215,495	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,166	2,541	12	0		90.00
91.00	09100	EMERGENCY	1,197	14,216	47	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)	1,971,573	6,297,429	262	0		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	UNUSED SPACE	0	0	0	0		192.01
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)	48,903	8,490,479	499,620	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.024804	1.348245	1,906.946565	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,115	223,517	211,671	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.010710	0.035493	807.904580	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | 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	5,841,750		5,841,750	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,529,086		5,529,086	0	0	50.00
51.00	05100	RECOVERY ROOM	433,884		433,884	0	0	51.00
53.00	05300	ANESTHESIOLOGY	455,449		455,449	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,978,386		2,978,386	0	0	54.00
60.00	06000	LABORATORY	3,376,794		3,376,794	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,756,421		1,756,421	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	784,332	0	784,332	0	0	65.00
65.01	03610	SLEEP LAB	2,251,446	0	2,251,446	0	0	65.01
65.02	03950	GERIATRIC PSYCH	621,490	0	621,490	0	0	65.02
66.00	06600	PHYSICAL THERAPY	1,666,111	0	1,666,111	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,167,756		1,167,756	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,180,213		1,180,213	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,755,145		8,755,145	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	687,589		687,589	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,070,539		1,070,539	0	0	90.00
91.00	09100	EMERGENCY	3,114,638		3,114,638	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	467,052		467,052		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	42,138,081	0	42,138,081	0	0	200.00
201.00		Less Observation Beds	467,052		467,052		0	201.00
202.00		Total (see instructions)	41,671,029	0	41,671,029	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,392,038		2,392,038			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	478,337	23,958,831	24,437,168	0.226257	0.000000	50.00
51.00	05100	RECOVERY ROOM	57,340	6,565,757	6,623,097	0.065511	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	81,042	3,761,459	3,842,501	0.118529	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	957,729	36,804,134	37,761,863	0.078873	0.000000	54.00
60.00	06000	LABORATORY	1,557,294	29,300,911	30,858,205	0.109429	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	56,059	3,393,971	3,450,030	0.509103	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	724,813	2,356,995	3,081,808	0.254504	0.000000	65.00
65.01	03610	SLEEP LAB	425	11,106,710	11,107,135	0.202703	0.000000	65.01
65.02	03950	GERIATRIC PSYCH	0	618,008	618,008	1.005634	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	1,642,073	3,392,068	5,034,141	0.330962	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,566	3,527,006	3,565,572	0.327509	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54,677	3,276,290	3,330,967	0.354315	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,375,685	20,166,569	22,542,254	0.388388	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,395,842	1,395,842	0.492598	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,382	2,693,589	2,695,971	0.397088	0.000000	90.00
91.00	09100	EMERGENCY	254,902	10,214,221	10,469,123	0.297507	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	22,547	482,545	505,092	0.924687	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,695,909	163,014,906	173,710,815			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,695,909	163,014,906	173,710,815			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		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
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	03610	SLEEP LAB	0.000000	65.01
65.02	03950	GERIATRIC PSYCH	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I | Date/Time Prepared: 8/8/2017 1:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,841,750		5,841,750	0	5,841,750	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,529,086		5,529,086	0	5,529,086	50.00
51.00	05100	RECOVERY ROOM	433,884		433,884	0	433,884	51.00
53.00	05300	ANESTHESIOLOGY	455,449		455,449	0	455,449	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,978,386		2,978,386	0	2,978,386	54.00
60.00	06000	LABORATORY	3,376,794		3,376,794	0	3,376,794	60.00
64.00	06400	INTRAVENOUS THERAPY	1,756,421		1,756,421	0	1,756,421	64.00
65.00	06500	RESPIRATORY THERAPY	784,332	0	784,332	0	784,332	65.00
65.01	03610	SLEEP LAB	2,251,446	0	2,251,446	0	2,251,446	65.01
65.02	03950	GERIATRIC PSYCH	621,490	0	621,490	0	621,490	65.02
66.00	06600	PHYSICAL THERAPY	1,666,111	0	1,666,111	0	1,666,111	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,167,756		1,167,756	0	1,167,756	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,180,213		1,180,213	0	1,180,213	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,755,145		8,755,145	0	8,755,145	73.00
76.97	07697	CARDIAC REHABILITATION	687,589		687,589	0	687,589	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,070,539		1,070,539	0	1,070,539	90.00
91.00	09100	EMERGENCY	3,114,638		3,114,638	0	3,114,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	467,052		467,052		467,052	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	42,138,081	0	42,138,081	0	42,138,081	200.00
201.00		Less Observation Beds	467,052		467,052		467,052	201.00
202.00		Total (see instructions)	41,671,029	0	41,671,029	0	41,671,029	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I | Date/Time Prepared: 8/8/2017 1:04 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	2,392,038		2,392,038			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	478,337	23,958,831	24,437,168	0.226257	0.000000	50.00
51.00	05100	RECOVERY ROOM	57,340	6,565,757	6,623,097	0.065511	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	81,042	3,761,459	3,842,501	0.118529	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	957,729	36,804,134	37,761,863	0.078873	0.000000	54.00
60.00	06000	LABORATORY	1,557,294	29,300,911	30,858,205	0.109429	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	56,059	3,393,971	3,450,030	0.509103	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	724,813	2,356,995	3,081,808	0.254504	0.000000	65.00
65.01	03610	SLEEP LAB	425	11,106,710	11,107,135	0.202703	0.000000	65.01
65.02	03950	GERIATRIC PSYCH	0	618,008	618,008	1.005634	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	1,642,073	3,392,068	5,034,141	0.330962	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,566	3,527,006	3,565,572	0.327509	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54,677	3,276,290	3,330,967	0.354315	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,375,685	20,166,569	22,542,254	0.388388	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,395,842	1,395,842	0.492598	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,382	2,693,589	2,695,971	0.397088	0.000000	90.00
91.00	09100	EMERGENCY	254,902	10,214,221	10,469,123	0.297507	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	22,547	482,545	505,092	0.924687	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,695,909	163,014,906	173,710,815			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,695,909	163,014,906	173,710,815			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet C Part I Date/Time Prepared: 8/8/2017 1:04 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
		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
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	03610	SLEEP LAB	0.000000	65.01
65.02	03950	GERIATRIC PSYCH	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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 ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part II Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

		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	789,409	24,437,168	0.032304	247,554	7,997	50.00
51.00	05100	RECOVERY ROOM	76,016	6,623,097	0.011477	27,892	320	51.00
53.00	05300	ANESTHESIOLOGY	14,158	3,842,501	0.003685	39,495	146	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	265,896	37,761,863	0.007041	446,885	3,147	54.00
60.00	06000	LABORATORY	190,246	30,858,205	0.006165	532,622	3,284	60.00
64.00	06400	INTRAVENOUS THERAPY	101,069	3,450,030	0.029295	14,304	419	64.00
65.00	06500	RESPIRATORY THERAPY	46,608	3,081,808	0.015124	227,220	3,436	65.00
65.01	03610	SLEEP LAB	238,713	11,107,135	0.021492	0	0	65.01
65.02	03950	GERIATRIC PSYCH	66,353	618,008	0.107366	0	0	65.02
66.00	06600	PHYSICAL THERAPY	64,472	5,034,141	0.012807	106,485	1,364	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,287	3,565,572	0.005970	16,669	100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,411	3,330,967	0.006428	29,454	189	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,835	22,542,254	0.010373	468,004	4,855	73.00
76.97	07697	CARDIAC REHABILITATION	97,648	1,395,842	0.069956	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	150,848	2,695,971	0.055953	2,178	122	90.00
91.00	09100	EMERGENCY	311,072	10,469,123	0.029713	13,869	412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	69,470	505,092	0.137539	0	0	92.00
200.00		Total (lines 50-199)	2,758,511	171,318,777		2,172,631	25,791	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

		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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
65.02	03950	GERIATRIC PSYCH	0	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

		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	24,437,168	0.000000	0.000000	247,554	50.00
51.00	05100	RECOVERY ROOM	0	6,623,097	0.000000	0.000000	27,892	51.00
53.00	05300	ANESTHESIOLOGY	0	3,842,501	0.000000	0.000000	39,495	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,761,863	0.000000	0.000000	446,885	54.00
60.00	06000	LABORATORY	0	30,858,205	0.000000	0.000000	532,622	60.00
64.00	06400	INTRAVENOUS THERAPY	0	3,450,030	0.000000	0.000000	14,304	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,081,808	0.000000	0.000000	227,220	65.00
65.01	03610	SLEEP LAB	0	11,107,135	0.000000	0.000000	0	65.01
65.02	03950	GERIATRIC PSYCH	0	618,008	0.000000	0.000000	0	65.02
66.00	06600	PHYSICAL THERAPY	0	5,034,141	0.000000	0.000000	106,485	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,565,572	0.000000	0.000000	16,669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,330,967	0.000000	0.000000	29,454	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,542,254	0.000000	0.000000	468,004	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,395,842	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,695,971	0.000000	0.000000	2,178	90.00
91.00	09100	EMERGENCY	0	10,469,123	0.000000	0.000000	13,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	505,092	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	171,318,777			2,172,631	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1334

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

Worksheet D Part IV

Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

		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	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
65.02	03950	GERIATRIC PSYCH	0	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

		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
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	03610	SLEEP LAB	0	0	65.01
65.02	03950	GERIATRIC PSYCH	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	66.00
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: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

		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	0.226257	0	7,733,621	0	0	50.00
51.00	05100	RECOVERY ROOM	0.065511	0	2,195,824	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.118529	0	1,192,120	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078873	0	11,538,509	0	0	54.00
60.00	06000	LABORATORY	0.109429	0	8,991,931	4,642	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.509103	0	1,401,993	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.254504	0	865,460	0	0	65.00
65.01	03610	SLEEP LAB	0.202703	0	2,212,173	0	0	65.01
65.02	03950	GERIATRIC PSYCH	1.005634	0	551,984	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.330962	0	921,665	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327509	0	1,428,557	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354315	0	2,080,316	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388388	0	7,802,043	1,642	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.492598	0	526,890	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.397088	0	1,606,214	0	0	90.00
91.00	09100	EMERGENCY	0.297507	0	2,606,438	1,449	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.924687	0	341,124	0	0	92.00
200.00		Subtotal (see instructions)		0	53,996,862	7,733	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	53,996,862	7,733	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,749,786	0	50.00
51.00	05100	RECOVERY ROOM	143,851	0	51.00
53.00	05300	ANESTHESIOLOGY	141,301	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	910,077	0	54.00
60.00	06000	LABORATORY	983,978	508	60.00
64.00	06400	INTRAVENOUS THERAPY	713,759	0	64.00
65.00	06500	RESPIRATORY THERAPY	220,263	0	65.00
65.01	03610	SLEEP LAB	448,414	0	65.01
65.02	03950	GERIATRIC PSYCH	555,094	0	65.02
66.00	06600	PHYSICAL THERAPY	305,036	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	467,865	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	737,087	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,030,220	638	73.00
76.97	07697	CARDIAC REHABILITATION	259,545	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	637,808	0	90.00
91.00	09100	EMERGENCY	775,434	431	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	315,433	0	92.00
200.00		Subtotal (see instructions)	12,394,951	1,577	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	12,394,951	1,577	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Swing Beds - SNF | Cost

		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	0.226257	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.065511	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.118529	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078873	0	0	0	0	54.00
60.00	06000	LABORATORY	0.109429	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.509103	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.254504	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0.202703	0	0	0	0	65.01
65.02	03950	GERIATRIC PSYCH	1.005634	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.330962	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327509	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354315	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388388	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.492598	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.397088	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.297507	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.924687	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
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
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	03610	SLEEP LAB	0	0	65.01
65.02	03950	GERIATRIC PSYCH	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	66.00
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		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

	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)	4,778	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,587	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)	1,205	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	2,291	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)	900	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)	648	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)	1,361	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)	481	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	5,841,750	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)	3,901,412	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,940,338	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)	1,940,338	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)	1,222.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	792,264	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)	792,264	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

	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						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)	459,055	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,251,319	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,663,999	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	588,085	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,252,084	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)	382	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,222.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	467,052	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet D-1 Date/Time Prepared: 8/8/2017 1:04 pm
	Title XVIII	Hospital	Cost

	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	868,909	5,841,750	0.148741	467,052	69,470	90.00
91.00	Nursing School cost	0	5,841,750	0.000000	467,052	0	91.00
92.00	Allied health cost	0	5,841,750	0.000000	467,052	0	92.00
93.00	All other Medical Education	0	5,841,750	0.000000	467,052	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-3 | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Hospital | Cost

		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		494,713		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.226257	247,554	56,011	50.00
51.00	05100	RECOVERY ROOM	0.065511	27,892	1,827	51.00
53.00	05300	ANESTHESIOLOGY	0.118529	39,495	4,681	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078873	446,885	35,247	54.00
60.00	06000	LABORATORY	0.109429	532,622	58,284	60.00
64.00	06400	INTRAVENOUS THERAPY	0.509103	14,304	7,282	64.00
65.00	06500	RESPIRATORY THERAPY	0.254504	227,220	57,828	65.00
65.01	03610	SLEEP LAB	0.202703	0	0	65.01
65.02	03950	GERIATRIC PSYCH	1.005634	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.330962	106,485	35,242	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327509	16,669	5,459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354315	29,454	10,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388388	468,004	181,767	73.00
76.97	07697	CARDIAC REHABILITATION	0.492598	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.397088	2,178	865	90.00
91.00	09100	EMERGENCY	0.297507	13,869	4,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.924687	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,172,631	459,055	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)		2,172,631		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet D-3
	Component CCN: 14-Z334		Date/Time Prepared: 8/8/2017 1:04 pm
	Title XVIII	Swing Beds - SNF	Cost

		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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.226257	0	0	50.00
51.00	05100	RECOVERY ROOM	0.065511	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.118529	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078873	170,003	13,409	54.00
60.00	06000	LABORATORY	0.109429	321,694	35,203	60.00
64.00	06400	INTRAVENOUS THERAPY	0.509103	8,213	4,181	64.00
65.00	06500	RESPIRATORY THERAPY	0.254504	128,660	32,744	65.00
65.01	03610	SLEEP LAB	0.202703	0	0	65.01
65.02	03950	GERIATRIC PSYCH	1.005634	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.330962	883,820	292,511	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327509	2,498	818	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354315	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388388	831,134	322,802	73.00
76.97	07697	CARDIAC REHABILITATION	0.492598	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.397088	204	81	90.00
91.00	09100	EMERGENCY	0.297507	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.924687	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,346,226	701,749	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)		2,346,226		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-3 | Date/Time Prepared: 8/8/2017 1:04 pm

Title XIX | Swing Beds - SNF | Cost

		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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.226257	0	0	50.00
51.00	05100	RECOVERY ROOM	0.065511	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.118529	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078873	0	0	54.00
60.00	06000	LABORATORY	0.109429	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.509103	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.254504	0	0	65.00
65.01	03610	SLEEP LAB	0.202703	0	0	65.01
65.02	03950	GERIATRIC PSYCH	1.005634	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.330962	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327509	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.354315	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388388	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.492598	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.397088	0	0	90.00
91.00	09100	EMERGENCY	0.297507	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.924687	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part B Date/Time Prepared: 8/8/2017 1:04 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12,396,528	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	12,396,528	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	12,520,493	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	9,259,213	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,808,106	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)	2,808,106	30.00
31.00	Primary payer payments	1,711	31.00
32.00	Subtotal (line 30 minus line 31)	2,806,395	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,593,515	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,035,785	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	907,337	36.00
37.00	Subtotal (see instructions)	3,842,180	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)	3,842,180	40.00
40.01	Sequestration adjustment (see instructions)	76,844	40.01
41.00	Interim payments	4,115,780	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-350,444	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: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet E-1 Part I Date/Time Prepared: 8/8/2017 1:04 pm
	Title XVIII	Hospital	Cost

		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		1,442,491		5,607,985	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		09/27/2016	259,795	09/27/2016	267,574	3.51
3.52		03/07/2017	11,891	12/15/2016	872,168	3.52
3.53			0	03/07/2017	352,463	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)		-271,686		-1,492,205	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)		1,170,805		4,115,780	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		90,374		350,444	6.02
7.00	Total Medicare program liability (see instructions)		1,080,431		3,765,336	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: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 8/8/2017 1:04 pm

Title XVIII | Swing Beds - SNF | Cost

		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		3,137,165		0	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		12/15/2016	68,081		0	3.51
3.52		03/07/2017	99,022		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)		-167,103		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)		2,970,062		0	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		92,149		0	6.02
7.00	Total Medicare program liability (see instructions)		2,877,913		0	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: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet E-1 Part II Date/Time Prepared: 8/8/2017 1:04 pm
	Title XVIII	Hospital	Cost

		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	423	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	648	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	90	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,205	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	173,710,815	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,389,232	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2016 To 03/31/2017	Worksheet E-2 Date/Time Prepared: 8/8/2017 1:04 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,274,605	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	708,766	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,842	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,983,371	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,983,371	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,983,371	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	46,725	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,936,646	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,936,646	0	19.00
19.01	Sequestration adjustment (see instructions)	58,733	0	19.01
20.00	Interim payments	2,970,062	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-92,149	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E-2 | Date/Time Prepared: 8/8/2017 1:04 pm

Title XIX | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E-3 Part V Date/Time Prepared: 8/8/2017 1:04 pm

	Title XVIII	Hospital	Cost	
			1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT			
1.00	Inpatient services		1,251,319	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,251,319	4.00
5.00	Primary payer payments		2,554	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,261,278	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
	Customary charges			
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,261,278	19.00
20.00	Deductibles (exclude professional component)		199,360	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,061,918	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,061,918	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		62,405	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		40,563	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		30,742	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,102,481	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (see instructions)		1,102,481	30.00
30.01	Sequestration adjustment (see instructions)		22,050	30.01
31.00	Interim payments		1,170,805	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)		-90,374	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G | Date/Time Prepared: 8/8/2017 1:04 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	480,079	0	1,000	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	52,317,099	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-31,751,023	0	0	0	6.00
7.00	Inventory	1,139,648	0	0	0	7.00
8.00	Prepaid expenses	107,004	0	0	0	8.00
9.00	Other current assets	54,690	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)	22,347,497	0	1,000	0	11.00
	FIXED ASSETS					
12.00	Land	171,136	0	0	0	12.00
13.00	Land improvements	1,137,794	0	0	0	13.00
14.00	Accumulated depreciation	-742,302	0	0	0	14.00
15.00	Buildings	24,883,959	0	0	0	15.00
16.00	Accumulated depreciation	-12,260,390	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	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	171,980	0	0	0	21.00
22.00	Accumulated depreciation	-106,271	0	0	0	22.00
23.00	Major movable equipment	13,768,281	0	0	0	23.00
24.00	Accumulated depreciation	-8,182,116	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	490,868	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,332,939	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,902,008	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,902,008	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	43,582,444	0	1,000	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,946,414	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,936,223	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	281,055	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	2,436,434	0	0	0	43.00
44.00	Other current liabilities	216,566	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,816,692	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	15,283,409	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	27,014	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,310,423	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,127,115	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	21,455,329				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			1,000		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)	21,455,329	0	1,000	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	43,582,444	0	1,000	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G-1 | Date/Time Prepared: 8/8/2017 1:04 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		17,092,033		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,040,306				2.00
3.00	Total (sum of line 1 and line 2)		23,132,339		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		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)		23,132,339		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	SJ CMA LAB/RADIOLOGY	1,677,008		0		0	14.00
15.00	TRANSFER	0		0		30,000	15.00
16.00	TRANSFERS	0		0		6,713	16.00
17.00	ROUNDING	2		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1,677,010		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		21,455,329		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	37,713		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)	37,713		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	37,713		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00	SJ CMA LAB/RADIOLOGY		0		14.00
15.00	TRANSFER		0		15.00
16.00	TRANSFERS		0		16.00
17.00	ROUNDING		0		17.00
18.00	Total deductions (sum of lines 12-17)	36,713		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	1,000		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1334 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/8/2017 1:04 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,791,310		1,791,310	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,117,900		1,117,900	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)	2,909,210		2,909,210	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,909,210		2,909,210	17.00
18.00	Ancillary services	8,298,104	166,023,415	174,321,519	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)	11,207,314	166,023,415	177,230,729	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,585,024		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)		40,585,024		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1334	Period: From 04/01/2016 To 03/31/2017	Worksheet G-3 Date/Time Prepared: 8/8/2017 1:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	177,230,729	1.00
2.00	Less contractual allowances and discounts on patients' accounts	113,911,225	2.00
3.00	Net patient revenues (line 1 minus line 2)	63,319,504	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,585,024	4.00
5.00	Net income from service to patients (line 3 minus line 4)	22,734,480	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	43,628	6.00
7.00	Income from investments	544,943	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	2,298	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	87,360	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	490	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	14,614	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	56,123	22.00
23.00	Governmental appropriations	58,672	23.00
24.00	MISCELLANEOUS	276	24.00
25.00	Total other income (sum of lines 6-24)	808,404	25.00
26.00	Total (line 5 plus line 25)	23,542,884	26.00
27.00	HOME OFC,LOSS ON EQUIP, CONTR TO AFF	17,502,578	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	17,502,578	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,040,306	29.00