This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet S Parts I-III Date/Time Prepared: 8/22/2018 12:49 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/22/2018 Time: 12:49 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HERRIN HOSPITAL (14-0011) for the cost reporting period beginning 04/01/2017 and ending 03/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII 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	1,799,240	193,472	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	10,324	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	1,809,564	193,472	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: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/22/2018 12:47 pm

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

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

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2017	03/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,145	0	0	0	31	167	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.	934	182	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/22/2018 12:47 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1	09/15/2014	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	04/01/2017	03/31/2018	38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/22/2018 12:47 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/22/2018 12:47 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part I Date/Time Prepared: 8/22/2018 12:47 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/22/2018 12:47 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	757,925	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H124	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/22/2018 12:47 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 1239 E. MAIN ST.	PO Box: 3988		142.00
143.00	City: CARBONDALE	State: IL	Zip Code: 62902-3988	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.			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.	Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		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)	10/01/2017	12/31/2017	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 8/22/2018 12:47 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	08/15/2018	Y	08/15/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

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		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.	Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	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.	618-457-52000	LUANNE.WARREN@SIH.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part II Date/Time Prepared: 8/22/2018 12:47 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: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part IX Date/Time Prepared: 8/22/2018 12:47 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. (see S-2, Part I, line 98)	N	N	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	N	N	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	N	N	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. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	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. (see S-2, Part I, line 98.05)	N	N	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. (see S-2, Part I, line 98.06)	N	N	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
	FQHC			
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 8/22/2018 12:47 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,105	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		77	28,105	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		85	31,025	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	29	10,585		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		114				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

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	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)	12,199	2,720	19,754			1.00
2.00	HMO and other (see instructions)	1,502	198				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	315	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	12,199	2,720	19,754			7.00
8.00	INTENSIVE CARE UNIT	1,372	425	2,158			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	13,571	3,145	21,912	0.00	754.33	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	4,631	1,116	7,421	0.00	61.00	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	815.33	27.00
28.00	Observation Bed Days		478	2,260			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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/22/2018 12:47 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,400	1,031	6,304	1.00
2.00	HMO and other (see instructions)			369	73		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	3,400	1,031	6,304	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	289	73	446	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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 8/22/2018 12:47 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	45,808,055	0	45,808,055	1,695,894.23	27.01	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		501,811	0	501,811	9,710.08	51.68	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,538,850	-131,714	3,407,136	126,878.33	26.85	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		489,242	0	489,242	6,994.62	69.95	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		140,104	0	140,104	636.00	220.29	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		7,784,706	0	7,784,706	232,488.32	33.48	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,891,659	0	8,891,659			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		723,049	0	723,049			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		106,492	0	106,492			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,847,360	0	2,847,360			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	143,388	0	143,388	4,670.03	30.70	26.00
27.00	Administrative & General	5.00	4,272,509	0	4,272,509	143,641.27	29.74	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 8/22/2018 12:47 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,117,920	0	1,117,920	2,560.86	436.54	28.00
29.00	Maintenance & Repairs	6.00	596,052	0	596,052	25,623.95	23.26	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	43,585	0	43,585	2,734.62	15.94	31.00
32.00	Housekeeping	9.00	1,196,079	0	1,196,079	84,482.27	14.16	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,067,710	-677,126	390,584	24,514.91	15.93	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	677,126	677,126	42,502.34	15.93	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	846,993	0	846,993	27,097.35	31.26	38.00
39.00	Central Services and Supply	14.00	196,475	0	196,475	11,819.43	16.62	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	353,321	0	353,321	20,468.50	17.26	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 8/22/2018 12:47 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		46,424,164	0	46,424,164	1,688,745.01	27.49	1.00
2.00	Excluded area salaries (see instructions)		3,538,850	-131,714	3,407,136	126,878.33	26.85	2.00
3.00	Subtotal salaries (line 1 minus line 2)		42,885,314	131,714	43,017,028	1,561,866.68	27.54	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,414,052	0	8,414,052	240,118.94	35.04	4.00
5.00	Subtotal wage-related costs (see inst.)		11,739,019	0	11,739,019	0.00	27.29	5.00
6.00	Total (sum of lines 3 thru 5)		63,038,385	131,714	63,170,099	1,801,985.62	35.06	6.00
7.00	Total overhead cost (see instructions)		9,834,032	0	9,834,032	390,115.53	25.21	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 8/22/2018 12:47 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	752,571	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	539	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,991,072	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	78,885	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	21,811	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	124,644	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	586,030	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	695,656	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,325,910	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	32,169	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	111,913	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,721,200	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part V | Date/Time Prepared: 8/22/2018 12:47 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	489,242	9,721,200	1.00
2.00	Hospital	489,242	9,721,200	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-10 | Date/Time Prepared: 8/22/2018 12:47 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)	0.215113	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	15,320,110	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,437,004	5.00
6.00	Medicaid charges	126,922,666	6.00
7.00	Medicaid cost (line 1 times line 6)	27,302,715	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)	9,545,601	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	34,982	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	9,545,601	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,237,041	1,645,665	4,882,706	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	696,330	1,645,665	2,341,995	21.00
22.00	Payments received from patients for amounts previously written off as charity care	2,681	19,794	22,475	22.00
23.00	Cost of charity care (line 21 minus line 22)	693,649	1,625,871	2,319,520	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,671,708	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,301,144	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,001,760	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,669,948	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,705,183	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,024,703	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,570,304	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A | Date/Time Prepared: 8/22/2018 12:47 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		4,275,179	4,275,179	21,188	4,296,367	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,206,940	3,206,940	7,210	3,214,150	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	143,388	13,941,974	14,085,362	0	14,085,362	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	252,284	99,495	351,779	0	351,779	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,054,825	47,794	1,102,619	0	1,102,619	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,965,400	5,407,818	8,373,218	-239	8,372,979	5.04
6.00	00600	MAINTENANCE & REPAIRS	596,052	977,401	1,573,453	0	1,573,453	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,585	436,977	480,562	0	480,562	8.00
9.00	00900	HOUSEKEEPING	1,196,079	322,652	1,518,731	0	1,518,731	9.00
10.00	01000	DIETARY	1,067,710	788,533	1,856,243	-1,177,202	679,041	10.00
11.00	01100	CAFETERIA	0	0	0	1,177,202	1,177,202	11.00
13.00	01300	NURSING ADMINISTRATION	846,993	385,633	1,232,626	0	1,232,626	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	196,475	50,949	247,424	0	247,424	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	353,321	34,176	387,497	0	387,497	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,686,468	2,686,468	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,601,924	6,260,778	14,862,702	-47,961	14,814,741	30.00
31.00	03100	INTENSIVE CARE UNIT	1,735,169	629,260	2,364,429	-10,123	2,354,306	31.00
41.00	04100	SUBPROVIDER - IRF	3,407,136	1,618,917	5,026,053	-2,283	5,023,770	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,433,551	7,081,090	10,514,641	-3,350,504	7,164,137	50.00
51.00	05100	RECOVERY ROOM	697,874	136,165	834,039	0	834,039	51.00
53.00	05300	ANESTHESIOLOGY	391,330	3,082,585	3,473,915	-2,726,796	747,119	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,094,581	740,788	2,835,369	-61,139	2,774,230	54.00
56.00	05600	RADIOISOTOPE	223,620	1,141,209	1,364,829	0	1,364,829	56.00
57.00	05700	CT SCAN	454,920	409,242	864,162	-64,005	800,157	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	281,836	192,494	474,330	-56,374	417,956	58.00
60.00	06000	LABORATORY	1,878,686	4,224,682	6,103,368	570,066	6,673,434	60.00
65.00	06500	RESPIRATORY THERAPY	1,148,438	254,482	1,402,920	-65,444	1,337,476	65.00
66.00	06600	PHYSICAL THERAPY	6,075,070	2,049,997	8,125,067	-60	8,125,007	66.00
69.00	06900	ELECTROCARDIOLOGY	909,680	422,034	1,331,714	-205,477	1,126,237	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,651,638	3,651,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,671,324	6,671,324	0	6,671,324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,939,958	5,325,210	7,265,168	336,508	7,601,676	73.00
76.97	07697	CARDIAC REHABILITATION	429,184	23,305	452,489	0	452,489	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	143,392	421,000	564,392	-10,056	554,336	90.00
91.00	09100	EMERGENCY	3,113,880	5,698,865	8,812,745	-26,543	8,786,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,236,733	1,236,733	-28,398	1,208,335	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,676,341	77,595,681	123,272,022	617,676	123,889,698	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	106,346	106,346	0	106,346	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	131,714	485,962	617,676	-617,676	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	45,808,055	78,187,989	123,996,044	0	123,996,044	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A | Date/Time Prepared: 8/22/2018 12:47 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	-47,768	4,248,599		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,039,271	6,253,421		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-108,346	13,977,016		4.00
5.01	00550	DATA PROCESSING	7,422,568	7,422,568		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-5,042	346,737		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,288,244	3,390,863		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,854,338	12,227,317		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	1,573,453		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	480,562		8.00
9.00	00900	HOUSEKEEPING	0	1,518,731		9.00
10.00	01000	DIETARY	0	679,041		10.00
11.00	01100	CAFETERIA	-533,950	643,252		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,232,626		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	247,424		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-63,973	323,524		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-2,686,468	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,541,029	11,273,712		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,354,306		31.00
41.00	04100	SUBPROVIDER - IRF	-1,237,424	3,786,346		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-64,557	7,099,580		50.00
51.00	05100	RECOVERY ROOM	0	834,039		51.00
53.00	05300	ANESTHESIOLOGY	0	747,119		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-69,350	2,704,880		54.00
56.00	05600	RADIOISOTOPE	0	1,364,829		56.00
57.00	05700	CT SCAN	0	800,157		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	417,956		58.00
60.00	06000	LABORATORY	-263,599	6,409,835		60.00
65.00	06500	RESPIRATORY THERAPY	-14,339	1,323,137		65.00
66.00	06600	PHYSICAL THERAPY	-227,281	7,897,726		66.00
69.00	06900	ELECTROCARDIOLOGY	-69,223	1,057,014		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,651,638		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,671,324		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,601,676		73.00
76.97	07697	CARDIAC REHABILITATION	-703	451,786		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	888	555,224		90.00
91.00	09100	EMERGENCY	-4,390,809	4,395,393		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-1,208,335	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,073,113	125,962,811		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-45,051	61,295		192.00
192.01	19201	VACANT SPACE	0	0		192.01
192.02	19202	REFERENCE LAB	0	0		192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	2,028,062	126,024,106		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet Non-CMS W | Date/Time Prepared: 8/22/2018 12:47 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00	MAINTENANCE & REPAIRS	00600		6.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697		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 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	VACANT SPACE	19201		192.01
192.02	REFERENCE LAB	19202		192.02
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-6 | Date/Time Prepared: 8/22/2018 12:47 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	677,126	500,076	1.00
	TOTALS		677,126	500,076	
	B - MEDICAL SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,651,638	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
	TOTALS		0	3,651,638	
	C - CRNA RECLASS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,686,468	1.00
	TOTALS		0	2,686,468	
	D - INTEREST RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	21,188	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,210	2.00
	TOTALS		0	28,398	
	E - CONTRAST DRUG RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	336,895	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	336,895	
	F - REFERENCE LAB RECLASS				
1.00	LABORATORY	60.00	131,714	485,962	1.00
	TOTALS		131,714	485,962	
500.00	Grand Total: Increases		808,840	7,689,437	500.00

RECLASSIFICATIONS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-6 | Date/Time Prepared: 8/22/2018 12:47 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	677,126	500,076	0		1.00
	TOTALS		677,126	500,076			
	B - MEDICAL SUPPLY RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	239	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	47,961	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	2,283	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	10,123	0		4.00
5.00	OPERATING ROOM	50.00	0	3,350,504	0		5.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	5	0		6.00
7.00	EMERGENCY	91.00	0	26,543	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	40,328	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	36,342	0		9.00
10.00	CT SCAN	57.00	0	3,956	0		10.00
11.00	LABORATORY	60.00	0	47,610	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	65,444	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	60	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	9,797	0		14.00
15.00	CLINIC	90.00	0	10,056	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	387	0		16.00
	TOTALS		0	3,651,638			
	C - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	2,686,468	0		1.00
	TOTALS		0	2,686,468			
	D - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	28,398	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	28,398			
	E - CONTRAST DRUG RECLASS						
1.00	ELECTROCARDIOLOGY	69.00	0	195,680	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	24,797	0		2.00
3.00	CT SCAN	57.00	0	60,049	0		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	56,369	0		4.00
	TOTALS		0	336,895			
	F - REFERENCE LAB RECLASS						
1.00	REFERENCE LAB	192.02	131,714	485,962	0		1.00
	TOTALS		131,714	485,962			
500.00	Grand Total: Decreases		808,840	7,689,437			500.00

RECLASSIFICATIONS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 8/22/2018 12:47 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - CAFETERIA RECLASS								
1.00	CAFETERIA	11.00	677,126	500,076	DIETARY	10.00	677,126	500,076	1.00
	TOTALS		677,126	500,076	TOTALS		677,126	500,076	
	B - MEDICAL SUPPLY RECLASS								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,651,638	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	239	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	47,961	2.00
3.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	2,283	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	10,123	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	3,350,504	5.00
6.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	5	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	26,543	7.00
8.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	40,328	8.00
9.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	36,342	9.00
10.00		0.00	0	0	CT SCAN	57.00	0	3,956	10.00
11.00		0.00	0	0	LABORATORY	60.00	0	47,610	11.00
12.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	65,444	12.00
13.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	60	13.00
14.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	9,797	14.00
15.00		0.00	0	0	CLINIC	90.00	0	10,056	15.00
16.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	387	16.00
	TOTALS		0	3,651,638	TOTALS		0	3,651,638	
	C - CRNA RECLASS								
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,686,468	ANESTHESIOLOGY	53.00	0	2,686,468	1.00
	TOTALS		0	2,686,468	TOTALS		0	2,686,468	
	D - INTEREST RECLASS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	21,188	INTEREST EXPENSE	113.00	0	28,398	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,210		0.00	0	0	2.00
	TOTALS		0	28,398	TOTALS		0	28,398	
	E - CONTRAST DRUG RECLASS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	336,895	ELECTROCARDIOLOGY	69.00	0	195,680	1.00
2.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	24,797	2.00
3.00		0.00	0	0	CT SCAN	57.00	0	60,049	3.00
4.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	56,369	4.00
	TOTALS		0	336,895	TOTALS		0	336,895	
	F - REFERENCE LAB RECLASS								
1.00	LABORATORY	60.00	131,714	485,962	REFERENCE LAB	192.02	131,714	485,962	1.00
	TOTALS		131,714	485,962	TOTALS		131,714	485,962	
500.00	Grand Total: Increases		808,840	7,689,437	Grand Total: Decreases		808,840	7,689,437	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 8/22/2018 12:47 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,119,371	198,927	0	198,927	0	1.00
2.00	Land Improvements	4,580,925	791,745	0	791,745	0	2.00
3.00	Buildings and Fixtures	84,375,692	10,488,384	0	10,488,384	4,319,836	3.00
4.00	Building Improvements	26,804	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	32,890,888	3,584,984	0	3,584,984	3,386,105	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	125,993,680	15,064,040	0	15,064,040	7,705,941	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	125,993,680	15,064,040	0	15,064,040	7,705,941	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,318,298	0	1.00
2.00	Land Improvements	5,372,670	0	2.00
3.00	Buildings and Fixtures	90,544,240	0	3.00
4.00	Building Improvements	26,804	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	33,089,767	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	133,351,779	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	133,351,779	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 8/22/2018 12:47 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	4,275,179	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,206,940	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,482,119	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	4,275,179	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,206,940	2.00
3.00	Total (sum of lines 1-2)	0	7,482,119	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 8/22/2018 12:47 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	46,176,051	0	46,176,051	0.921465	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,935,491	0	3,935,491	0.078535	0	2.00
3.00	Total (sum of lines 1-2)	50,111,542	0	50,111,542	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,248,599	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,253,421	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,502,020	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	4,248,599	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	6,253,421	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	10,502,020	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8 | Date/Time Prepared: 8/22/2018 12:47 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,564,398			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	24,522,988			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-533,950	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	-63,973	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-2,686,468	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8 | Date/Time Prepared: 8/22/2018 12:47 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	
33.00	INTEREST INCOME UNRESTRICTED	B	-1,074,027	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.00
33.01	PAYMENTS FOR EMPLOYEE OUTPATIENT SVC	B	-4,137,485	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	NONALLOWABLE BOND EXPENSE	A	-1,208,335	INTEREST EXPENSE	113.00	0	33.02
33.03	PURCHASE DISCOUNTS	B	-5,042	PURCHASING RECEIVING AND STORES	5.02	0	33.03
33.04	CABLE TV	A	-1,193	SUBPROVIDER - IRF	41.00	0	33.04
33.05	OFFSET OF LOBBYING EXPENSE	A	-22,891	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.05
33.06	COMMUNITY DONATIONS	A	-16,066	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.06
33.07	LEASEHOLD REVENUE	B	-313,304	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	DEBT FORGIVENESS	A	-112,272	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	FUNDED DEPRECIATION	A	-913	CAP REL COSTS-BLDG & FIXT	1.00	9	33.09
33.10	REAL ESTATE TAXES	A	-46,348	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.10
33.11	MEDICAID PROVIDER TAX	A	-2,831,056	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12	MISCELLANEOUS INCOME	B	-225	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13	CABLE TV	A	-488	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
33.14	COMMUNITY DONATIONS	A	-41	ADULTS & PEDIATRICS	30.00	0	33.14
33.15	XRAY FILM/SILVER REVENUE	B	-1,205	RADIOLOGY-DIAGNOSTIC	54.00	0	33.15
33.16	EKG DEPARTMENTAL PROGRAM REVENUE	B	-2,250	ELECTROCARDIOLOGY	69.00	0	33.16
33.17	IRF PHO INCENTIVE	B	-6,196	SUBPROVIDER - IRF	41.00	0	33.17
33.18	LOSS ON 1991 BONDS	A	79,778	CAP REL COSTS-BLDG & FIXT	1.00	9	33.18
33.19	LOSS ON 1991 BONDS	A	109,449	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20	CABLE TV	A	-514	CLINIC	90.00	0	33.20
33.21	REAL ESTATE TAXES	A	-45,051	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.21
33.22	MISCELLANEOUS INCOME	B	-562	CARDIAC REHABILITATION	76.97	0	33.22
33.23	REAL ESTATE TAXES	A	-9,036	PHYSICAL THERAPY	66.00	0	33.23
33.24	CABLE TV	A	-864	PHYSICAL THERAPY	66.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,028,062				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 8/22/2018 12:47 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	186,671	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,929,822	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	4,029,139	0	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	7,422,568	0	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	2,288,244	0	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	7,957,711	0	4.02
4.03	90.00	CLINIC	RENT	18,076	16,674	4.03
4.04	60.00	LABORATORY	RENT	24,757	57,178	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	RENT	51,801	119,946	4.05
4.06	66.00	PHYSICAL THERAPY	RENT	119,416	288,612	4.06
4.07	69.00	ELECTROCARDIOLOGY	RENT	34,649	57,456	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			25,062,854	539,866	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 8/22/2018 12:47 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	186,671	9		1.00
2.00	2,929,822	9		2.00
3.00	4,029,139	0		3.00
4.00	7,422,568	0		4.00
4.01	2,288,244	0		4.01
4.02	7,957,711	0		4.02
4.03	1,402	0		4.03
4.04	-32,421	0		4.04
4.05	-68,145	0		4.05
4.06	-169,196	0		4.06
4.07	-22,807	0		4.07
5.00	24,522,988			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 8/22/2018 12:47 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	DR. A	253,704	190,278	63,426	260,300	180	1.00
2.00	65.00	DR. B	25,096	8,125	16,971	179,000	125	2.00
3.00	69.00	DR. C	44,596	43,961	635	179,000	5	3.00
4.00	76.97	DR. D	743	0	743	179,000	7	4.00
5.00	91.00	DR. E	4,401,966	4,384,336	17,630	181,300	128	5.00
6.00	30.00	DR. F	3,540,988	3,540,988	0	0	0	6.00
7.00	41.00	DR. G	1,230,035	1,230,035	0	0	0	7.00
8.00	50.00	DR. H	87,183	46,483	40,700	246,400	191	8.00
9.00	66.00	DR. I	48,185	48,185	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			9,632,496	9,492,391	140,105		636	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	DR. A	22,526	1,126	0	0	0	1.00
2.00	65.00	DR. B	10,757	538	0	0	0	2.00
3.00	69.00	DR. C	430	22	0	0	0	3.00
4.00	76.97	DR. D	602	30	0	0	0	4.00
5.00	91.00	DR. E	11,157	558	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	41.00	DR. G	0	0	0	0	0	7.00
8.00	50.00	DR. H	22,626	1,131	0	0	0	8.00
9.00	66.00	DR. I	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			68,098	3,405	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	DR. A	0	22,526	40,900	231,178		1.00
2.00	65.00	DR. B	0	10,757	6,214	14,339		2.00
3.00	69.00	DR. C	0	430	205	44,166		3.00
4.00	76.97	DR. D	0	602	141	141		4.00
5.00	91.00	DR. E	0	11,157	6,473	4,390,809		5.00
6.00	30.00	DR. F	0	0	0	3,540,988		6.00
7.00	41.00	DR. G	0	0	0	1,230,035		7.00
8.00	50.00	DR. H	0	22,626	18,074	64,557		8.00
9.00	66.00	DR. I	0	0	0	48,185		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	68,098	72,007	9,564,398		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,248,599	4,248,599				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,253,421		6,253,421			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,977,016	30,421	4,908	14,012,345		4.00
5.01	00550	DATA PROCESSING	7,422,568	19,655	0	0	7,442,223	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	346,737	35,121	287	77,414	32,821	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,390,863	34,287	7,383	323,676	262,570	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	12,227,317	766,196	69,356	909,942	525,140	5.04
6.00	00600	MAINTENANCE & REPAIRS	1,573,453	522,532	12,166	182,900	155,901	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	480,562	0	616	13,374	0	8.00
9.00	00900	HOUSEKEEPING	1,518,731	56,368	23,107	367,020	16,411	9.00
10.00	01000	DIETARY	679,041	65,769	25,106	119,852	73,848	10.00
11.00	01100	CAFETERIA	643,252	78,563	0	207,778	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,232,626	19,617	315,083	259,902	32,821	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	247,424	44,010	0	60,289	8,205	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	323,524	0	15,824	108,418	172,312	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,273,712	720,710	354,802	2,639,534	1,263,621	30.00
31.00	03100	INTENSIVE CARE UNIT	2,354,306	83,699	193,514	532,442	147,696	31.00
41.00	04100	SUBPROVIDER - IRF	3,786,346	337,165	95,028	1,045,490	631,809	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,099,580	514,306	2,401,437	1,053,595	968,227	50.00
51.00	05100	RECOVERY ROOM	834,039	79,624	8,892	214,145	114,874	51.00
53.00	05300	ANESTHESIOLOGY	747,119	531	57,941	120,081	82,053	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,704,880	129,415	799,208	642,728	295,391	54.00
56.00	05600	RADIOISOTOPE	1,364,829	27,217	89,872	68,618	41,027	56.00
57.00	05700	CT SCAN	800,157	19,333	362,313	139,594	24,616	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	417,956	13,855	311,811	86,482	24,616	58.00
60.00	06000	LABORATORY	6,409,835	109,779	386,690	616,897	344,623	60.00
65.00	06500	RESPIRATORY THERAPY	1,323,137	59,818	108,166	352,402	196,928	65.00
66.00	06600	PHYSICAL THERAPY	7,897,726	136,561	81,586	1,864,153	1,091,307	66.00
69.00	06900	ELECTROCARDIOLOGY	1,057,014	51,232	188,378	279,138	270,775	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,651,638	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,671,324	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,601,676	35,993	63,177	595,282	139,490	73.00
76.97	07697	CARDIAC REHABILITATION	451,786	35,595	15,849	131,696	98,464	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	555,224	0	1,907	44,000	98,464	90.00
91.00	09100	EMERGENCY	4,395,393	191,090	255,722	955,503	328,213	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	125,962,811	4,218,462	6,250,129	14,012,345	7,442,223	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,471	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	61,295	11,562	3,292	0	0	192.00
192.01	19201	VACANT SPACE	0	2,104	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	126,024,106	4,248,599	6,253,421	14,012,345	7,442,223	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/22/2018 12:47 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	492,380					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,268	4,021,047				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	14,497,951	14,497,951		5.04
6.00	00600	MAINTENANCE & REPAIRS	10	0	2,446,962	318,095	2,765,057	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	494,552	64,290	0	8.00
9.00	00900	HOUSEKEEPING	24	0	1,981,661	257,608	54,873	9.00
10.00	01000	DIETARY	2	0	963,618	125,266	64,025	10.00
11.00	01100	CAFETERIA	3	0	929,596	120,844	76,479	11.00
13.00	01300	NURSING ADMINISTRATION	20	0	1,860,069	241,802	19,097	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	693	0	360,621	46,879	42,843	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	620,078	80,608	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	101,229	170,153	16,523,761	2,148,016	701,596	30.00
31.00	03100	INTENSIVE CARE UNIT	29,504	23,347	3,364,508	437,373	81,479	31.00
41.00	04100	SUBPROVIDER - IRF	14,781	99,326	6,009,945	781,269	328,224	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	219,412	555,458	12,812,015	1,665,511	500,666	50.00
51.00	05100	RECOVERY ROOM	468	48,310	1,300,352	169,041	77,512	51.00
53.00	05300	ANESTHESIOLOGY	9,352	85,516	1,102,593	143,333	517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,947	235,249	4,813,818	625,777	125,983	54.00
56.00	05600	RADIOISOTOPE	880	143,549	1,735,992	225,672	26,496	56.00
57.00	05700	CT SCAN	10,337	533,106	1,889,456	245,622	18,820	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	584	143,246	998,550	129,808	13,488	58.00
60.00	06000	LABORATORY	18,496	631,748	8,518,068	1,107,315	106,868	60.00
65.00	06500	RESPIRATORY THERAPY	9,686	61,804	2,111,941	274,544	58,231	65.00
66.00	06600	PHYSICAL THERAPY	3,389	292,274	11,366,996	1,477,664	132,939	66.00
69.00	06900	ELECTROCARDIOLOGY	1,903	189,297	2,037,737	264,898	49,873	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	140,915	3,792,553	493,017	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	143,284	6,814,608	885,872	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	360	191,060	8,627,038	1,121,480	35,038	73.00
76.97	07697	CARDIAC REHABILITATION	156	16,959	750,505	97,563	34,651	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,099	27,800	729,494	94,831	0	90.00
91.00	09100	EMERGENCY	59,777	288,646	6,474,344	841,639	186,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	492,380	4,021,047	125,929,382	14,485,637	2,735,720	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,471	2,141	16,034	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	76,149	9,899	11,255	192.00
192.01	19201	VACANT SPACE	0	0	2,104	274	2,048	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	492,380	4,021,047	126,024,106	14,497,951	2,765,057	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	558,842					8.00
9.00	00900	HOUSEKEEPING	0	2,294,142				9.00
10.00	01000	DIETARY	0	54,196	1,207,105			10.00
11.00	01100	CAFETERIA	0	64,739	0	1,191,658		11.00
13.00	01300	NURSING ADMINISTRATION	0	16,165	0	26,224	2,163,357	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,266	0	6,083	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	10,939	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	376,347	593,896	812,912	266,332	903,831	30.00
31.00	03100	INTENSIVE CARE UNIT	41,113	68,971	88,806	53,723	144,702	31.00
41.00	04100	SUBPROVIDER - IRF	141,382	277,838	305,387	105,488	376,166	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	423,809	0	106,306	358,644	50.00
51.00	05100	RECOVERY ROOM	0	65,613	0	21,607	53,710	51.00
53.00	05300	ANESTHESIOLOGY	0	437	0	12,116	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	106,643	0	64,850	0	54.00
56.00	05600	RADIOISOTOPE	0	22,428	0	6,923	0	56.00
57.00	05700	CT SCAN	0	15,931	0	14,085	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	11,417	0	8,726	0	58.00
60.00	06000	LABORATORY	0	90,462	0	62,244	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	49,292	0	35,557	0	65.00
66.00	06600	PHYSICAL THERAPY	0	112,531	0	188,090	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	42,217	0	28,165	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	29,660	0	60,063	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	29,332	0	13,288	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4,440	0	90.00
91.00	09100	EMERGENCY	0	157,466	0	96,409	326,304	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	558,842	2,269,309	1,207,105	1,191,658	2,163,357	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,572	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,527	0	0	0	192.00
192.01	19201	VACANT SPACE	0	1,734	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	558,842	2,294,142	1,207,105	1,191,658	2,163,357	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	492,692					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	711,625				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,697	30,113	0	22,362,501	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,203	4,132	0	4,286,010	0	31.00
41.00	04100	SUBPROVIDER - IRF	271	17,578	0	8,343,548	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	398,010	98,302	0	16,363,263	0	50.00
51.00	05100	RECOVERY ROOM	0	8,550	0	1,696,385	0	51.00
53.00	05300	ANESTHESIOLOGY	4,791	15,134	0	1,278,921	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,317	41,633	0	5,783,021	0	54.00
56.00	05600	RADIOISOTOPE	0	25,405	0	2,042,916	0	56.00
57.00	05700	CT SCAN	470	94,347	0	2,278,731	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1	25,351	0	1,187,341	0	58.00
60.00	06000	LABORATORY	64,593	111,803	0	10,061,353	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,774	10,938	0	2,548,277	0	65.00
66.00	06600	PHYSICAL THERAPY	7	51,725	0	13,329,952	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,164	33,501	0	2,457,555	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,938	0	4,310,508	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,358	0	7,725,838	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46	33,813	0	9,907,138	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	3,001	0	928,340	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,195	4,920	0	834,880	0	90.00
91.00	09100	EMERGENCY	3,153	51,083	0	8,136,420	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	492,692	711,625	0	125,862,898	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	48,218	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	106,830	0	192.00
192.01	19201	VACANT SPACE	0	0	0	6,160	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	492,692	711,625	0	126,024,106	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	DATA PROCESSING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL			5.04
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	22,362,501		30.00
31.00	03100	INTENSIVE CARE UNIT	4,286,010		31.00
41.00	04100	SUBPROVIDER - IRF	8,343,548		41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	16,363,263		50.00
51.00	05100	RECOVERY ROOM	1,696,385		51.00
53.00	05300	ANESTHESIOLOGY	1,278,921		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,783,021		54.00
56.00	05600	RADIOISOTOPE	2,042,916		56.00
57.00	05700	CT SCAN	2,278,731		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,187,341		58.00
60.00	06000	LABORATORY	10,061,353		60.00
65.00	06500	RESPIRATORY THERAPY	2,548,277		65.00
66.00	06600	PHYSICAL THERAPY	13,329,952		66.00
69.00	06900	ELECTROCARDIOLOGY	2,457,555		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,310,508		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,725,838		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,907,138		73.00
76.97	07697	CARDIAC REHABILITATION	928,340		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	834,880		90.00
91.00	09100	EMERGENCY	8,136,420		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	125,862,898		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48,218		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	106,830		192.00
192.01	19201	VACANT SPACE	6,160		192.01
192.02	19202	REFERENCE LAB	0		192.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	126,024,106		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet Non-CMS W | Date/Time Prepared: 8/22/2018 12:47 pm

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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	30,421	4,908	35,329	35,329	4.00
5.01	00550	DATA PROCESSING	0	19,655	0	19,655	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	35,121	287	35,408	195	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	34,287	7,383	41,670	816	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	766,196	69,356	835,552	2,295	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	522,532	12,166	534,698	461	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	616	616	34	8.00
9.00	00900	HOUSEKEEPING	0	56,368	23,107	79,475	926	9.00
10.00	01000	DIETARY	0	65,769	25,106	90,875	302	10.00
11.00	01100	CAFETERIA	0	78,563	0	78,563	524	11.00
13.00	01300	NURSING ADMINISTRATION	0	19,617	315,083	334,700	656	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	44,010	0	44,010	152	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	15,824	15,824	273	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	720,710	354,802	1,075,512	6,644	30.00
31.00	03100	INTENSIVE CARE UNIT	0	83,699	193,514	277,213	1,343	31.00
41.00	04100	SUBPROVIDER - IRF	0	337,165	95,028	432,193	2,637	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	514,306	2,401,437	2,915,743	2,658	50.00
51.00	05100	RECOVERY ROOM	0	79,624	8,892	88,516	540	51.00
53.00	05300	ANESTHESIOLOGY	0	531	57,941	58,472	303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	129,415	799,208	928,623	1,621	54.00
56.00	05600	RADIOISOTOPE	0	27,217	89,872	117,089	173	56.00
57.00	05700	CT SCAN	0	19,333	362,313	381,646	352	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,855	311,811	325,666	218	58.00
60.00	06000	LABORATORY	0	109,779	386,690	496,469	1,556	60.00
65.00	06500	RESPIRATORY THERAPY	0	59,818	108,166	167,984	889	65.00
66.00	06600	PHYSICAL THERAPY	0	136,561	81,586	218,147	4,702	66.00
69.00	06900	ELECTROCARDIOLOGY	0	51,232	188,378	239,610	704	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,993	63,177	99,170	1,502	73.00
76.97	07697	CARDIAC REHABILITATION	0	35,595	15,849	51,444	332	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,907	1,907	111	90.00
91.00	09100	EMERGENCY	0	191,090	255,722	446,812	2,410	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,218,462	6,250,129	10,468,591	35,329	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,471	0	16,471	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,562	3,292	14,854	0	192.00
192.01	19201	VACANT SPACE	0	2,104	0	2,104	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,248,599	6,253,421	10,502,020	35,329	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/22/2018 12:47 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	19,655					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	87	35,690				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	693	164	43,343			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,387	0	0	839,234		5.04
6.00	00600	MAINTENANCE & REPAIRS	412	1	0	18,413	553,985	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	3,722	0	8.00
9.00	00900	HOUSEKEEPING	43	2	0	14,912	10,994	9.00
10.00	01000	DIETARY	195	0	0	7,251	12,827	10.00
11.00	01100	CAFETERIA	0	0	0	6,995	15,323	11.00
13.00	01300	NURSING ADMINISTRATION	87	1	0	13,997	3,826	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22	50	0	2,714	8,584	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	455	0	0	4,666	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	3,338	7,338	1,838	124,343	140,566	30.00
31.00	03100	INTENSIVE CARE UNIT	390	2,139	252	25,318	16,325	31.00
41.00	04100	SUBPROVIDER - IRF	1,669	1,071	1,073	45,225	65,760	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,557	15,904	6,000	96,410	100,310	50.00
51.00	05100	RECOVERY ROOM	303	34	522	9,785	15,530	51.00
53.00	05300	ANESTHESIOLOGY	217	678	924	8,297	104	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	780	504	2,541	36,224	25,241	54.00
56.00	05600	RADIOISOTOPE	108	64	1,551	13,063	5,308	56.00
57.00	05700	CT SCAN	65	749	5,759	14,218	3,771	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	65	42	1,547	7,514	2,702	58.00
60.00	06000	LABORATORY	910	1,341	6,731	64,098	21,411	60.00
65.00	06500	RESPIRATORY THERAPY	520	702	668	15,892	11,667	65.00
66.00	06600	PHYSICAL THERAPY	2,882	246	3,157	85,537	26,635	66.00
69.00	06900	ELECTROCARDIOLOGY	715	138	2,045	15,334	9,992	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,522	28,539	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,548	51,280	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	368	26	2,064	64,918	7,020	73.00
76.97	07697	CARDIAC REHABILITATION	260	11	183	5,648	6,942	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	260	152	300	5,489	0	90.00
91.00	09100	EMERGENCY	867	4,333	3,118	48,719	37,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,655	35,690	43,343	838,521	548,108	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	124	3,212	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	573	2,255	192.00
192.01	19201	VACANT SPACE	0	0	0	16	410	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,655	35,690	43,343	839,234	553,985	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,372					8.00
9.00	00900	HOUSEKEEPING	0	106,352				9.00
10.00	01000	DIETARY	0	2,512	113,962			10.00
11.00	01100	CAFETERIA	0	3,001	0	104,406		11.00
13.00	01300	NURSING ADMINISTRATION	0	749	0	2,298	356,314	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,681	0	533	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	959	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	2,944	27,532	76,747	23,321	148,865	30.00
31.00	03100	INTENSIVE CARE UNIT	322	3,197	8,384	4,708	23,833	31.00
41.00	04100	SUBPROVIDER - IRF	1,106	12,880	28,831	9,244	61,956	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	19,647	0	9,315	59,070	50.00
51.00	05100	RECOVERY ROOM	0	3,042	0	1,893	8,846	51.00
53.00	05300	ANESTHESIOLOGY	0	20	0	1,062	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,944	0	5,683	0	54.00
56.00	05600	RADIOISOTOPE	0	1,040	0	607	0	56.00
57.00	05700	CT SCAN	0	739	0	1,234	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	529	0	765	0	58.00
60.00	06000	LABORATORY	0	4,194	0	5,454	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,285	0	3,116	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,217	0	16,482	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,957	0	2,468	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,375	0	5,263	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,360	0	1,164	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	389	0	90.00
91.00	09100	EMERGENCY	0	7,300	0	8,448	53,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,372	105,201	113,962	104,406	356,314	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	629	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	442	0	0	0	192.00
192.01	19201	VACANT SPACE	0	80	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,372	106,352	113,962	104,406	356,314	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,746					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,177				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	668	932		1,640,588	0	30.00
31.00	03100	INTENSIVE CARE UNIT	141	128		363,693	0	31.00
41.00	04100	SUBPROVIDER - IRF	32	544		664,221	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,649	3,041		3,277,304	0	50.00
51.00	05100	RECOVERY ROOM	0	264		129,275	0	51.00
53.00	05300	ANESTHESIOLOGY	561	468		71,106	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	506	1,288		1,007,955	0	54.00
56.00	05600	RADIOISOTOPE	0	786		139,789	0	56.00
57.00	05700	CT SCAN	55	2,919		411,507	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	784		339,832	0	58.00
60.00	06000	LABORATORY	7,571	3,622		613,357	0	60.00
65.00	06500	RESPIRATORY THERAPY	911	338		204,972	0	65.00
66.00	06600	PHYSICAL THERAPY	1	1,600		364,606	0	66.00
69.00	06900	ELECTROCARDIOLOGY	136	1,036		274,135	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	772		30,833	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	784		53,612	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5	1,046		182,757	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	93		67,437	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	140	152		8,900	0	90.00
91.00	09100	EMERGENCY	370	1,580		614,971	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,746	22,177	0	10,460,850	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		20,436	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		18,124	0	192.00
192.01	19201	VACANT SPACE	0	0		2,610	0	192.01
192.02	19202	REFERENCE LAB	0	0		0	0	192.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	57,746	22,177	0	10,502,020	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	DATA PROCESSING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL			5.04
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,640,588		30.00
31.00	03100	INTENSIVE CARE UNIT	363,693		31.00
41.00	04100	SUBPROVIDER - IRF	664,221		41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,277,304		50.00
51.00	05100	RECOVERY ROOM	129,275		51.00
53.00	05300	ANESTHESIOLOGY	71,106		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,007,955		54.00
56.00	05600	RADIOISOTOPE	139,789		56.00
57.00	05700	CT SCAN	411,507		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	339,832		58.00
60.00	06000	LABORATORY	613,357		60.00
65.00	06500	RESPIRATORY THERAPY	204,972		65.00
66.00	06600	PHYSICAL THERAPY	364,606		66.00
69.00	06900	ELECTROCARDIOLOGY	274,135		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,833		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,612		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	182,757		73.00
76.97	07697	CARDIAC REHABILITATION	67,437		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	8,900		90.00
91.00	09100	EMERGENCY	614,971		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,460,850		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,436		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,124		192.00
192.01	19201	VACANT SPACE	2,610		192.01
192.02	19202	REFERENCE LAB	0		192.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	10,502,020		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	224,158					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,206,941				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,605	2,517	45,664,667			4.00
5.01	00550	DATA PROCESSING	1,037	0	0	907		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,853	147	252,284	4	6,533,065	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,809	3,786	1,054,825	32	30,094	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	40,425	35,568	2,965,400	64	5	5.04
6.00	00600	MAINTENANCE & REPAIRS	27,569	6,239	596,052	19	130	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	316	43,585	0	0	8.00
9.00	00900	HOUSEKEEPING	2,974	11,850	1,196,079	2	324	9.00
10.00	01000	DIETARY	3,470	12,875	390,584	9	22	10.00
11.00	01100	CAFETERIA	4,145	0	677,126	0	38	11.00
13.00	01300	NURSING ADMINISTRATION	1,035	161,584	846,993	4	266	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,322	0	196,475	1	9,201	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,115	353,321	21	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	38,025	181,953	8,601,924	154	1,343,148	30.00
31.00	03100	INTENSIVE CARE UNIT	4,416	99,240	1,735,169	18	391,468	31.00
41.00	04100	SUBPROVIDER - IRF	17,789	48,733	3,407,136	77	196,118	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,135	1,231,528	3,433,551	118	2,911,202	50.00
51.00	05100	RECOVERY ROOM	4,201	4,560	697,874	14	6,206	51.00
53.00	05300	ANESTHESIOLOGY	28	29,714	391,330	10	124,092	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,828	409,858	2,094,581	36	92,179	54.00
56.00	05600	RADIOISOTOPE	1,436	46,089	223,620	5	11,674	56.00
57.00	05700	CT SCAN	1,020	185,805	454,920	3	137,151	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731	159,906	281,836	3	7,746	58.00
60.00	06000	LABORATORY	5,792	198,306	2,010,400	42	245,417	60.00
65.00	06500	RESPIRATORY THERAPY	3,156	55,471	1,148,438	24	128,516	65.00
66.00	06600	PHYSICAL THERAPY	7,205	41,840	6,075,070	133	44,972	66.00
69.00	06900	ELECTROCARDIOLOGY	2,703	96,606	909,680	33	25,256	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,899	32,399	1,939,958	17	4,775	73.00
76.97	07697	CARDIAC REHABILITATION	1,878	8,128	429,184	12	2,076	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	978	143,392	12	27,849	90.00
91.00	09100	EMERGENCY	10,082	131,142	3,113,880	40	793,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	222,568	3,205,253	45,664,667	907	6,533,065	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	869	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	610	1,688	0	0	0	192.00
192.01	19201	VACANT SPACE	111	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,248,599	6,253,421	14,012,345	7,442,223	492,380	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.953591	1.949964	0.306853	8,205.317530	0.075367	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			35,329	19,655	35,690	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000774	21.670342	0.005463	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.03	5A.04	5.04	6.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	594,967,300					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-14,497,951	111,526,155			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	2,446,962	149,860		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	494,552	0	29,333	8.00
9.00	00900	HOUSEKEEPING	0	0	1,981,661	2,974	0	9.00
10.00	01000	DIETARY	0	0	963,618	3,470	0	10.00
11.00	01100	CAFETERIA	0	0	929,596	4,145	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,860,069	1,035	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	360,621	2,322	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	620,078	0	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	25,177,945	0	16,523,761	38,025	19,754	30.00
31.00	03100	INTENSIVE CARE UNIT	3,454,778	0	3,364,508	4,416	2,158	31.00
41.00	04100	SUBPROVIDER - IRF	14,697,610	0	6,009,945	17,789	7,421	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,192,686	0	12,812,015	27,135	0	50.00
51.00	05100	RECOVERY ROOM	7,148,562	0	1,300,352	4,201	0	51.00
53.00	05300	ANESTHESIOLOGY	12,654,044	0	1,102,593	28	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,810,394	0	4,813,818	6,828	0	54.00
56.00	05600	RADIOISOTOPE	21,241,391	0	1,735,992	1,436	0	56.00
57.00	05700	CT SCAN	78,885,181	0	1,889,456	1,020	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,196,530	0	998,550	731	0	58.00
60.00	06000	LABORATORY	93,443,136	0	8,518,068	5,792	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,145,323	0	2,111,941	3,156	0	65.00
66.00	06600	PHYSICAL THERAPY	43,248,652	0	11,366,996	7,205	0	66.00
69.00	06900	ELECTROCARDIOLOGY	28,010,765	0	2,037,737	2,703	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,851,577	0	3,792,553	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,202,182	0	6,814,608	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,271,734	0	8,627,038	1,899	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,509,424	0	750,505	1,878	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,113,696	0	729,494	0	0	90.00
91.00	09100	EMERGENCY	42,711,690	0	6,474,344	10,082	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 through 117)	594,967,300	-14,497,951	111,431,431	148,270	29,333	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,471	869	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	76,149	610	0	192.00
192.01	19201	VACANT SPACE	0	0	2,104	111	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,021,047		14,497,951	2,765,057	558,842	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006758		0.129996	18.450934	19.051648	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,343		839,234	553,985	4,372	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000073		0.007525	3.696684	0.149047	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	146,886					9.00
10.00	01000	DIETARY	3,470	87,999				10.00
11.00	01100	CAFETERIA	4,145	0	38,488,732			11.00
13.00	01300	NURSING ADMINISTRATION	1,035	0	846,993	729,685		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,322	0	196,475	0	4,147,542	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	353,321	0	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	38,025	59,262	8,601,924	304,856	47,961	30.00
31.00	03100	INTENSIVE CARE UNIT	4,416	6,474	1,735,169	48,807	10,123	31.00
41.00	04100	SUBPROVIDER - IRF	17,789	22,263	3,407,136	126,878	2,283	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,135	0	3,433,551	120,968	3,350,504	50.00
51.00	05100	RECOVERY ROOM	4,201	0	697,874	18,116	0	51.00
53.00	05300	ANESTHESIOLOGY	28	0	391,330	0	40,328	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,828	0	2,094,581	0	36,342	54.00
56.00	05600	RADIOISOTOPE	1,436	0	223,620	0	0	56.00
57.00	05700	CT SCAN	1,020	0	454,920	0	3,956	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731	0	281,836	0	5	58.00
60.00	06000	LABORATORY	5,792	0	2,010,400	0	543,753	60.00
65.00	06500	RESPIRATORY THERAPY	3,156	0	1,148,438	0	65,444	65.00
66.00	06600	PHYSICAL THERAPY	7,205	0	6,075,070	0	60	66.00
69.00	06900	ELECTROCARDIOLOGY	2,703	0	909,680	0	9,797	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,899	0	1,939,958	0	387	73.00
76.97	07697	CARDIAC REHABILITATION	1,878	0	429,184	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	143,392	0	10,056	90.00
91.00	09100	EMERGENCY	10,082	0	3,113,880	110,060	26,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,296	87,999	38,488,732	729,685	4,147,542	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	869	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	610	0	0	0	0	192.00
192.01	19201	VACANT SPACE	111	0	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,294,142	1,207,105	1,191,658	2,163,357	492,692	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.618520	13.717258	0.030961	2.964782	0.118791	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	106,352	113,962	104,406	356,314	57,746	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.724044	1.295037	0.002713	0.488312	0.013923	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/22/2018 12:47 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	594,967,300			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	25,177,945	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,454,778	0		31.00
41.00	04100	SUBPROVIDER - IRF	14,697,610	0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	82,192,686	0		50.00
51.00	05100	RECOVERY ROOM	7,148,562	0		51.00
53.00	05300	ANESTHESIOLOGY	12,654,044	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,810,394	0		54.00
56.00	05600	RADIOISOTOPE	21,241,391	0		56.00
57.00	05700	CT SCAN	78,885,181	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,196,530	0		58.00
60.00	06000	LABORATORY	93,443,136	0		60.00
65.00	06500	RESPIRATORY THERAPY	9,145,323	0		65.00
66.00	06600	PHYSICAL THERAPY	43,248,652	0		66.00
69.00	06900	ELECTROCARDIOLOGY	28,010,765	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,851,577	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,202,182	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,271,734	0		73.00
76.97	07697	CARDIAC REHABILITATION	2,509,424	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4,113,696	0		90.00
91.00	09100	EMERGENCY	42,711,690	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 through 117)	594,967,300	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	VACANT SPACE	0	0		192.01
192.02	19202	REFERENCE LAB	0	0		192.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	711,625	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001196	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,177	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000037	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		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	22,362,501		22,362,501	0	22,362,501	30.00
31.00	03100	INTENSIVE CARE UNIT	4,286,010		4,286,010	0	4,286,010	31.00
41.00	04100	SUBPROVIDER - IRF	8,343,548		8,343,548	0	8,343,548	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,363,263		16,363,263	18,074	16,381,337	50.00
51.00	05100	RECOVERY ROOM	1,696,385		1,696,385	0	1,696,385	51.00
53.00	05300	ANESTHESIOLOGY	1,278,921		1,278,921	0	1,278,921	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,783,021		5,783,021	0	5,783,021	54.00
56.00	05600	RADIOISOTOPE	2,042,916		2,042,916	0	2,042,916	56.00
57.00	05700	CT SCAN	2,278,731		2,278,731	0	2,278,731	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,187,341		1,187,341	0	1,187,341	58.00
60.00	06000	LABORATORY	10,061,353		10,061,353	40,900	10,102,253	60.00
65.00	06500	RESPIRATORY THERAPY	2,548,277	0	2,548,277	6,214	2,554,491	65.00
66.00	06600	PHYSICAL THERAPY	13,329,952	0	13,329,952	0	13,329,952	66.00
69.00	06900	ELECTROCARDIOLOGY	2,457,555		2,457,555	205	2,457,760	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,310,508		4,310,508	0	4,310,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,725,838		7,725,838	0	7,725,838	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,907,138		9,907,138	0	9,907,138	73.00
76.97	07697	CARDIAC REHABILITATION	928,340		928,340	141	928,481	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	834,880		834,880	0	834,880	90.00
91.00	09100	EMERGENCY	8,136,420		8,136,420	6,473	8,142,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,295,776		2,295,776		2,295,776	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	128,158,674	0	128,158,674	72,007	128,230,681	200.00
201.00		Less Observation Beds	2,295,776		2,295,776		2,295,776	201.00
202.00		Total (see instructions)	125,862,898	0	125,862,898	72,007	125,934,905	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,250,747		21,250,747			30.00
31.00	03100	INTENSIVE CARE UNIT	3,454,778		3,454,778			31.00
41.00	04100	SUBPROVIDER - IRF	13,347,035		13,347,035			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,995,419	44,868,259	80,863,678	0.202356	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,707,043	3,085,125	6,792,168	0.249756	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	5,413,649	6,992,517	12,406,166	0.103088	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,414,069	28,704,303	34,118,372	0.169499	0.000000	54.00
56.00	05600	RADIOISOTOPE	3,049,767	17,935,567	20,985,334	0.097350	0.000000	56.00
57.00	05700	CT SCAN	20,827,353	57,216,710	78,044,063	0.029198	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,084,132	16,586,144	20,670,276	0.057442	0.000000	58.00
60.00	06000	LABORATORY	25,474,790	66,191,430	91,666,220	0.109761	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,905,080	2,211,015	9,116,095	0.279536	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	12,208,091	30,230,328	42,438,419	0.314101	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	9,549,536	17,942,277	27,491,813	0.089392	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,153,242	6,476,029	20,629,271	0.208951	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,737,897	5,288,472	21,026,369	0.367436	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,916,966	6,138,284	28,055,250	0.353130	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	1,594	2,471,949	2,473,543	0.375308	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	131,875	3,981,732	4,113,607	0.202956	0.000000	90.00
91.00	09100	EMERGENCY	10,925,538	31,360,756	42,286,294	0.192413	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	420,184	3,452,756	3,872,940	0.592773	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	233,968,785	351,133,653	585,102,438			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	233,968,785	351,133,653	585,102,438			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.202580	50.00
51.00	05100	RECOVERY ROOM	0.249756	51.00
53.00	05300	ANESTHESIOLOGY	0.103088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169499	54.00
56.00	05600	RADIOISOTOPE	0.097350	56.00
57.00	05700	CT SCAN	0.029198	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057442	58.00
60.00	06000	LABORATORY	0.110207	60.00
65.00	06500	RESPIRATORY THERAPY	0.280218	65.00
66.00	06600	PHYSICAL THERAPY	0.314101	66.00
69.00	06900	ELECTROCARDIOLOGY	0.089400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.208951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.353130	73.00
76.97	07697	CARDIAC REHABILITATION	0.375365	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.202956	90.00
91.00	09100	EMERGENCY	0.192566	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.592773	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 12:47 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,362,501		22,362,501	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,286,010		4,286,010	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	8,343,548		8,343,548	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,363,263		16,363,263	0	0	50.00
51.00	05100	RECOVERY ROOM	1,696,385		1,696,385	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,278,921		1,278,921	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,783,021		5,783,021	0	0	54.00
56.00	05600	RADIOISOTOPE	2,042,916		2,042,916	0	0	56.00
57.00	05700	CT SCAN	2,278,731		2,278,731	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,187,341		1,187,341	0	0	58.00
60.00	06000	LABORATORY	10,061,353		10,061,353	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,548,277	0	2,548,277	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,329,952	0	13,329,952	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,457,555		2,457,555	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,310,508		4,310,508	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,725,838		7,725,838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,907,138		9,907,138	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	928,340		928,340	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	834,880		834,880	0	0	90.00
91.00	09100	EMERGENCY	8,136,420		8,136,420	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	125,862,898	0	125,862,898	0	0	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	125,862,898	0	125,862,898	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 12:47 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 12:47 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part I Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,640,588	0	1,640,588	22,014	74.52	30.00
31.00	INTENSIVE CARE UNIT	363,693		363,693	2,158	168.53	31.00
41.00	SUBPROVIDER - IRF	664,221	0	664,221	7,421	89.51	41.00
200.00	Total (lines 30 through 199)	2,668,502		2,668,502	31,593		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	12,199	909,069		30.00
31.00	INTENSIVE CARE UNIT	1,372	231,223		31.00
41.00	SUBPROVIDER - IRF	4,631	414,521		41.00
200.00	Total (lines 30 through 199)	18,202	1,554,813		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part II Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,277,304	80,863,678	0.040529	17,225,117	698,117	50.00
51.00	05100	RECOVERY ROOM	129,275	6,792,168	0.019033	1,646,294	31,334	51.00
53.00	05300	ANESTHESIOLOGY	71,106	12,406,166	0.005732	2,456,137	14,079	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,007,955	34,118,372	0.029543	2,509,141	74,128	54.00
56.00	05600	RADIOISOTOPE	139,789	20,985,334	0.006661	1,830,963	12,196	56.00
57.00	05700	CT SCAN	411,507	78,044,063	0.005273	11,000,486	58,006	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	339,832	20,670,276	0.016441	2,074,882	34,113	58.00
60.00	06000	LABORATORY	613,357	91,666,220	0.006691	15,253,335	102,060	60.00
65.00	06500	RESPIRATORY THERAPY	204,972	9,116,095	0.022485	4,155,154	93,429	65.00
66.00	06600	PHYSICAL THERAPY	364,606	42,438,419	0.008591	2,693,759	23,142	66.00
69.00	06900	ELECTROCARDIOLOGY	274,135	27,491,813	0.009972	5,366,255	53,512	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,833	20,629,271	0.001495	5,356,404	8,008	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,612	21,026,369	0.002550	7,660,675	19,535	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	182,757	28,055,250	0.006514	12,328,477	80,308	73.00
76.97	07697	CARDIAC REHABILITATION	67,437	2,473,543	0.027263	1,413	39	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,900	4,113,607	0.002164	127,895	277	90.00
91.00	09100	EMERGENCY	614,971	42,286,294	0.014543	5,728,049	83,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	168,425	3,872,940	0.043488	335,716	14,600	92.00
200.00		Total (lines 50 through 199)	7,960,773	547,049,878		97,750,152	1,400,186	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part III Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	22,014	0.00	12,199	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,158	0.00	1,372	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	7,421	0.00	4,631	41.00
200.00		Total (lines 30 through 199)		0	31,593		18,202	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost		
			9.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
200.00		Total (lines 30 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	80,863,678	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,792,168	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,406,166	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,118,372	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	20,985,334	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,044,063	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20,670,276	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	91,666,220	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,116,095	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	42,438,419	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	27,491,813	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20,629,271	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,026,369	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,055,250	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,473,543	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4,113,607	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,286,294	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,872,940	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	547,049,878		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	17,225,117	0	14,784,447	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,646,294	0	1,204,227	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,456,137	0	2,207,415	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,509,141	0	8,140,515	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	1,830,963	0	8,664,549	0	56.00
57.00	05700	CT SCAN	0.000000	11,000,486	0	19,803,030	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,074,882	0	5,148,853	0	58.00
60.00	06000	LABORATORY	0.000000	15,253,335	0	7,800,485	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,155,154	0	924,633	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,693,759	0	125,518	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,366,255	0	6,871,977	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5,356,404	0	2,014,570	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,660,675	0	1,771,600	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,328,477	0	3,403,569	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	1,413	0	971,049	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	127,895	0	2,302,431	0	90.00
91.00	09100	EMERGENCY	0.000000	5,728,049	0	7,992,270	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	335,716	0	1,518,744	0	92.00
200.00		Total (lines 50 through 199)		97,750,152	0	95,649,882	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.202356	14,784,447	0	0	2,991,722	50.00
51.00	05100	RECOVERY ROOM	0.249756	1,204,227	0	0	300,763	51.00
53.00	05300	ANESTHESIOLOGY	0.103088	2,207,415	0	0	227,558	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169499	8,140,515	0	0	1,379,809	54.00
56.00	05600	RADIOISOTOPE	0.097350	8,664,549	0	0	843,494	56.00
57.00	05700	CT SCAN	0.029198	19,803,030	0	0	578,209	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057442	5,148,853	0	0	295,760	58.00
60.00	06000	LABORATORY	0.109761	7,800,485	1,348	0	856,189	60.00
65.00	06500	RESPIRATORY THERAPY	0.279536	924,633	0	0	258,468	65.00
66.00	06600	PHYSICAL THERAPY	0.314101	125,518	0	0	39,425	66.00
69.00	06900	ELECTROCARDIOLOGY	0.089392	6,871,977	0	0	614,300	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.208951	2,014,570	0	0	420,946	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367436	1,771,600	0	0	650,950	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.353130	3,403,569	0	32,317	1,201,902	73.00
76.97	07697	CARDIAC REHABILITATION	0.375308	971,049	0	0	364,442	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.202956	2,302,431	0	0	467,292	90.00
91.00	09100	EMERGENCY	0.192413	7,992,270	0	0	1,537,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.592773	1,518,744	0	0	900,270	92.00
200.00		Subtotal (see instructions)		95,649,882	1,348	32,317	13,929,316	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		95,649,882	1,348	32,317	13,929,316	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	148	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,412		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)	148	11,412		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	148	11,412		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part II | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,277,304	80,863,678	0.040529	52,439	2,125	50.00
51.00	05100	RECOVERY ROOM	129,275	6,792,168	0.019033	3,708	71	51.00
53.00	05300	ANESTHESIOLOGY	71,106	12,406,166	0.005732	1,431	8	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,007,955	34,118,372	0.029543	188,914	5,581	54.00
56.00	05600	RADIOISOTOPE	139,789	20,985,334	0.006661	20,069	134	56.00
57.00	05700	CT SCAN	411,507	78,044,063	0.005273	259,980	1,371	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	339,832	20,670,276	0.016441	19,921	328	58.00
60.00	06000	LABORATORY	613,357	91,666,220	0.006691	982,655	6,575	60.00
65.00	06500	RESPIRATORY THERAPY	204,972	9,116,095	0.022485	354,245	7,965	65.00
66.00	06600	PHYSICAL THERAPY	364,606	42,438,419	0.008591	5,258,092	45,172	66.00
69.00	06900	ELECTROCARDIOLOGY	274,135	27,491,813	0.009972	75,631	754	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,833	20,629,271	0.001495	21,224	32	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,612	21,026,369	0.002550	6,107	16	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	182,757	28,055,250	0.006514	1,399,252	9,115	73.00
76.97	07697	CARDIAC REHABILITATION	67,437	2,473,543	0.027263	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,900	4,113,607	0.002164	3,980	9	90.00
91.00	09100	EMERGENCY	614,971	42,286,294	0.014543	1,856	27	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,872,940	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	7,792,348	547,049,878		8,649,504	79,283	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	80,863,678	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,792,168	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,406,166	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,118,372	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	20,985,334	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,044,063	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20,670,276	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	91,666,220	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,116,095	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	42,438,419	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	27,491,813	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20,629,271	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,026,369	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,055,250	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,473,543	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4,113,607	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,286,294	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,872,940	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	547,049,878		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	52,439	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	3,708	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,431	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	188,914	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	20,069	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	259,980	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	19,921	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	982,655	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	354,245	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,258,092	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	75,631	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	21,224	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,107	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,399,252	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	3,980	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,856	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		8,649,504	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part IV Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
			21.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part I | Date/Time Prepared: 8/22/2018 12:47 pm

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,640,588	0	1,640,588	22,014	74.52	30.00
31.00	INTENSIVE CARE UNIT	363,693		363,693	2,158	168.53	31.00
41.00	SUBPROVIDER - IRF	664,221	0	664,221	7,421	89.51	41.00
200.00	Total (lines 30 through 199)	2,668,502		2,668,502	31,593		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,720	202,694				30.00
31.00	INTENSIVE CARE UNIT	425	71,625				31.00
41.00	SUBPROVIDER - IRF	1,116	99,893				41.00
200.00	Total (lines 30 through 199)	4,261	374,212				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part II Date/Time Prepared: 8/22/2018 12:47 pm

Title XIX | 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	3,277,304	0	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	129,275	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	71,106	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,007,955	0	0.000000	0	0	54.00
56.00	05600	RADIOISOTOPE	139,789	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	411,507	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	339,832	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	613,357	0	0.000000	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	204,972	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	364,606	0	0.000000	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	274,135	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,833	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,612	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	182,757	0	0.000000	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	67,437	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,900	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	614,971	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	7,792,348	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part III Date/Time Prepared: 8/22/2018 12:47 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	22,014	0.00	2,720	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,158	0.00	425	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	7,421	0.00	1,116	41.00
200.00		Total (lines 30 through 199)		0	31,593		4,261	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost		
			9.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
200.00		Total (lines 30 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 12:47 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 12:47 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 12:47 pm

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 12:47 pm

Title XIX | Hospital | Cost

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	22,014	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,014	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)	19,754	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	12,199	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	22,362,501	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	22,362,501	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)	22,362,501	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)	1,015.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	12,392,110	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)	12,392,110	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,286,010	2,158	1,986.10	1,372	2,724,929	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)	18,985,086	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	34,102,125	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,140,292	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,400,186	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,540,478	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	31,561,647	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,260	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,015.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,295,776	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,640,588	22,362,501	0.073363	2,295,776	168,425	90.00
91.00	Nursing School cost	0	22,362,501	0.000000	2,295,776	0	91.00
92.00	Allied health cost	0	22,362,501	0.000000	2,295,776	0	92.00
93.00	All other Medical Education	0	22,362,501	0.000000	2,295,776	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2017 To 03/31/2018	Worksheet D-1 Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,421	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,421	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,421	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,631	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,343,548	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,343,548	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)	8,343,548	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)	1,124.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,206,726	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,206,726	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,422,263	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,628,989	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)	414,521	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	79,283	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	493,804	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,135,185	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2017 To 03/31/2018	Worksheet D-1 Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	664,221	8,343,548	0.079609	0	0	90.00
91.00	Nursing School cost	0	8,343,548	0.000000	0	0	91.00
92.00	Allied health cost	0	8,343,548	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,343,548	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-3 | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		11,148,109		30.00
31.00	03100	INTENSIVE CARE UNIT		2,004,576		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202580	17,225,117	3,489,464	50.00
51.00	05100	RECOVERY ROOM	0.249756	1,646,294	411,172	51.00
53.00	05300	ANESTHESIOLOGY	0.103088	2,456,137	253,198	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169499	2,509,141	425,297	54.00
56.00	05600	RADIOISOTOPE	0.097350	1,830,963	178,244	56.00
57.00	05700	CT SCAN	0.029198	11,000,486	321,192	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057442	2,074,882	119,185	58.00
60.00	06000	LABORATORY	0.110207	15,253,335	1,681,024	60.00
65.00	06500	RESPIRATORY THERAPY	0.280218	4,155,154	1,164,349	65.00
66.00	06600	PHYSICAL THERAPY	0.314101	2,693,759	846,112	66.00
69.00	06900	ELECTROCARDIOLOGY	0.089400	5,366,255	479,743	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.208951	5,356,404	1,119,226	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367436	7,660,675	2,814,808	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.353130	12,328,477	4,353,555	73.00
76.97	07697	CARDIAC REHABILITATION	0.375365	1,413	530	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.202956	127,895	25,957	90.00
91.00	09100	EMERGENCY	0.192566	5,728,049	1,103,027	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.592773	335,716	199,003	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		97,750,152	18,985,086	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)		97,750,152		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-3 | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		8,385,953		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202580	52,439	10,623	50.00
51.00	05100	RECOVERY ROOM	0.249756	3,708	926	51.00
53.00	05300	ANESTHESIOLOGY	0.103088	1,431	148	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169499	188,914	32,021	54.00
56.00	05600	RADIOISOTOPE	0.097350	20,069	1,954	56.00
57.00	05700	CT SCAN	0.029198	259,980	7,591	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057442	19,921	1,144	58.00
60.00	06000	LABORATORY	0.110207	982,655	108,295	60.00
65.00	06500	RESPIRATORY THERAPY	0.280218	354,245	99,266	65.00
66.00	06600	PHYSICAL THERAPY	0.314101	5,258,092	1,651,572	66.00
69.00	06900	ELECTROCARDIOLOGY	0.089400	75,631	6,761	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.208951	21,224	4,435	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367436	6,107	2,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.353130	1,399,252	494,118	73.00
76.97	07697	CARDIAC REHABILITATION	0.375365	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.202956	3,980	808	90.00
91.00	09100	EMERGENCY	0.192566	1,856	357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.592773	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,649,504	2,422,263	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		8,649,504		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part A Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	11,599,544	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	12,228,615	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	578,639	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	78.81	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	6.59	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.26	31.00
32.00	Sum of lines 30 and 31	21.85	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.24	33.00
34.00	Disproportionate share adjustment (see instructions)	431,290	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part A Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	487,713	704,701	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	244,525	351,385	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	595,910		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	25,433,998		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	29,399,462		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		28,408,096	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,943,135	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		30,351,231	59.00
60.00	Primary payer payments		5,165	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		30,346,066	61.00
62.00	Deductibles billed to program beneficiaries		2,953,812	62.00
63.00	Coinsurance billed to program beneficiaries		83,586	63.00
64.00	Allowable bad debts (see instructions)		1,201,252	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		780,814	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		916,411	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		28,089,482	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		8,485	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-61,416	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		67,599	70.93
70.94	HRR adjustment amount (see instructions)		-491,959	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part A Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		27,612,191	71.00
71.01	Sequestration adjustment (see instructions)		552,244	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		25,260,707	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,799,240	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	1,491,123	1,482,975	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0033945320	1.0023079974	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	5,062	3,423	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9792	0.9795	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-31,015	-30,401	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet DSH | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	6.59	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	15.26	0.00			15.26	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	21.85	0.00			15.26	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	78.81	0.00			78.81	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	7.24	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	4.08	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	3,145	0			3,145	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	31	0			31	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	167	0			167	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	3,343	0			3,343	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	21,912	0			21,912	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	21,912	0			21,912	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	15.26	0.00			15.26	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet DSH | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	7.24		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00
30.00	Line 28 or 29 as applicable		7.24		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		7.24		0.00		31.00

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet DSH Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Hospital	PPS

		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	2.67		29.00
30.00	Line 28 or 29 as applicable	2.67		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part B Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	11,560	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	13,929,316	2.00
3.00	OPPS payments	10,442,861	3.00
4.00	Outlier payment (see instructions)	25,934	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.804	5.00
6.00	Line 2 times line 5	11,199,170	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	93.48	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)	11,560	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	33,665	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	33,665	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	33,665	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	22,105	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	11,560	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	10,468,795	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	189,011	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,023,031	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	8,268,313	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	8,268,313	30.00
31.00	Primary payer payments	176	31.00
32.00	Subtotal (line 30 minus line 31)	8,268,137	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)	779,791	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	506,864	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	610,591	36.00
37.00	Subtotal (see instructions)	8,775,001	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)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	8,775,001	40.00
40.01	Sequestration adjustment (see instructions)	175,500	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	8,406,029	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	193,472	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part B Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Hospital	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		27,475,508		8,406,029	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	03/29/2018	2,214,801		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-2,214,801		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)		25,260,707		8,406,029	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		1,799,240		193,472	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		27,059,947		8,599,501	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0011 | Component CCN: 14-T011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 8/22/2018 12:47 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,963,188		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			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,963,188		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		10,324		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,973,512		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: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet E-1 Part II Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2017 To 03/31/2018	Worksheet E-3 Part III Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	5,237,610	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0408	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	299,591	3.00
4.00	Outlier Payments	646,997	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	20.331507	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	6,184,198	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	6,184,198	17.00
18.00	Primary payer payments	5,864	18.00
19.00	Subtotal (line 17 less line 18).	6,178,334	19.00
20.00	Deductibles	38,380	20.00
21.00	Subtotal (line 19 minus line 20)	6,139,954	21.00
22.00	Coinsurance	58,000	22.00
23.00	Subtotal (line 21 minus line 22)	6,081,954	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	20,717	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	13,466	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,717	26.00
27.00	Subtotal (sum of lines 23 and 25)	6,095,420	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	6,095,420	32.00
32.01	Sequestration adjustment (see instructions)	121,908	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	5,963,188	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	10,324	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	646,997	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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

Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G | Date/Time Prepared: 8/22/2018 12:47 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	4,995,457	0	6,173	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	20,000	0	0	0	3.00
4.00	Accounts receivable	104,446,729	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-76,167,654	0	0	0	6.00
7.00	Inventory	2,052,532	0	0	0	7.00
8.00	Prepaid expenses	362,119	0	0	0	8.00
9.00	Other current assets	458,664	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)	36,167,847	0	6,173	0	11.00
	FIXED ASSETS					
12.00	Land	4,318,298	0	0	0	12.00
13.00	Land improvements	5,372,670	0	0	0	13.00
14.00	Accumulated depreciation	-3,071,692	0	0	0	14.00
15.00	Buildings	90,544,240	0	0	0	15.00
16.00	Accumulated depreciation	-43,095,904	0	0	0	16.00
17.00	Leasehold improvements	26,804	0	0	0	17.00
18.00	Accumulated depreciation	-8,455	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	250,962	0	0	0	21.00
22.00	Accumulated depreciation	-215,465	0	0	0	22.00
23.00	Major movable equipment	32,838,805	0	0	0	23.00
24.00	Accumulated depreciation	-20,131,265	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	66,828,998	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	52,174	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	1,546,348	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,598,522	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	104,595,367	0	6,173	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,288,846	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,766,155	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	702,965	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	5,752,797	0	0	0	43.00
44.00	Other current liabilities	650,548	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,161,311	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	43,783,807	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	23,233	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	43,807,040	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	60,968,351	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	43,627,016				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			6,173		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)	43,627,016	0	6,173	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	104,595,367	0	6,173	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G-1 | Date/Time Prepared: 8/22/2018 12:47 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		45,486,068		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,273,359				2.00
3.00	Total (sum of line 1 and line 2)		43,212,709		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RECLASS	414,307		0		0	5.00
6.00	RESTRICTED GRANT FUNDS	0		0		15,688	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)		414,307		0		10.00
11.00	Subtotal (line 3 plus line 10)		43,627,016		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	RESTRICTED GRANT TRANSACTIONS	0		0		54,272	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		43,627,016		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	44,757		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)	44,757		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	RECLASS		0			5.00
6.00	RESTRICTED GRANT FUNDS		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)	15,688		0		10.00
11.00	Subtotal (line 3 plus line 10)	60,445		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00	RESTRICTED GRANT TRANSACTIONS		0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	54,272		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	6,173		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0011 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 8/22/2018 12:47 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	25,159,315		25,159,315	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	13,700,665		13,700,665	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	38,859,980		38,859,980	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,454,778		3,454,778	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)	3,454,778		3,454,778	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,314,758		42,314,758	17.00
18.00	Ancillary services	195,527,139	357,125,402	552,652,541	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)	237,841,897	357,125,402	594,967,299	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		123,996,044		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)		123,996,044		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet G-3 Date/Time Prepared: 8/22/2018 12:47 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	594,967,299	1.00
2.00	Less contractual allowances and discounts on patients' accounts	425,484,222	2.00
3.00	Net patient revenues (line 1 minus line 2)	169,483,077	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	123,996,044	4.00
5.00	Net income from service to patients (line 3 minus line 4)	45,487,033	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,509,457	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	5,042	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	533,950	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	1,205	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	63,973	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	313,305	22.00
23.00	Governmental appropriations	34,982	23.00
24.00	MISC.,DEPARTMENTAL,PHO INCENTIVE	9,229	24.00
25.00	Total other income (sum of lines 6-24)	2,471,143	25.00
26.00	Total (line 5 plus line 25)	47,958,176	26.00
27.00	CORP ALLOC, CONTRIBUTIONS	50,231,535	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	50,231,535	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,273,359	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0011	Period: From 04/01/2017 To 03/31/2018	Worksheet L Parts I-III Date/Time Prepared: 8/22/2018 12:47 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,908,086	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	35,049	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	60.03	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,943,135	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00