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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1334	Period: From 04/01/2017 To 03/31/2018	Worksheet S Parts I-III Date/Time Prepared: 8/22/2018 10:37 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/22/2018 Time: 10:37 am
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 SAINT JOSEPH MEMORIAL HOSPITAL (14-1334) 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	55,302	4,154	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	160,994	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	216,296	4,154	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/22/2018 10:32 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2 SOUTH HOSPITAL DRIVE	PO Box:			1.00
2.00	City: MURPHYSBORO	State: IL	Zip Code: 62966	County:	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SAINT JOSEPH MEMORIAL HOSPITAL	141334	16060	1	05/01/2004	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST JOSEPH HOSPITAL SWING BED	14Z334	16060		11/14/2013	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 8/22/2018 10:32 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2	09/15/2014	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/22/2018 10:32 am

		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.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1334	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part I Date/Time Prepared: 8/22/2018 10:32 am

		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.	Y	Y	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.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A 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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/22/2018 10:32 am

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	258,144	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain 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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/22/2018 10:32 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 1239 E MAIN	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)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 8/22/2018 10:32 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	08/03/2018	Y	08/03/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 8/22/2018 10:32 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		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.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN	41.00
42.00	Enter the employer/company name of the cost report preparer.	SIH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200	LUANNE.WARREN@SIH.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1334	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part II Date/Time Prepared: 8/22/2018 10:32 am

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

HFS Supplemental Information | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part IX Date/Time Prepared: 8/22/2018 10:32 am

		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)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient	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)	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
	FQHC			
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/22/2018 10:32 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	32,984.05	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	32,984.05	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	32,984.05	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/22/2018 10:32 am

	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)	845	194	1,404			1.00
2.00	HMO and other (see instructions)	115	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	2,139	0	2,948			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	440			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,984	194	4,792			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2,984	194	4,792	0.00	232.62	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	232.62	27.00
28.00	Observation Bed Days		61	312			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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/22/2018 10:32 am

	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	239	69	420	1.00
2.00	HMO and other (see instructions)			38	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	239	69	420	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-10 | Date/Time Prepared: 8/22/2018 10:32 am

		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)	0.249025	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,783,778	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	1,463,036	5.00
6.00	Medicaid charges	40,923,509	6.00
7.00	Medicaid cost (line 1 times line 6)	10,190,977	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)	1,944,163	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	20,965	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,944,163	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)	962,912	426,320	1,389,232	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	239,789	426,320	666,109	21.00
22.00	Payments received from patients for amounts previously written off as charity care	2,574	7,704	10,278	22.00
23.00	Cost of charity care (line 21 minus line 22)	237,215	418,616	655,831	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)	3,009,739	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,369,041	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,106,216	27.01
28.00	Non-Medicare bad debt expense (see instructions)	903,523	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	962,175	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,618,006	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,562,169	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,346,962	1,346,962	57,721	1,404,683	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,445,080	1,445,080	31,080	1,476,160	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	150,525	4,441,417	4,591,942	0	4,591,942	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	35,031	39,757	74,788	0	74,788	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	560,920	20,952	581,872	0	581,872	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	700,769	1,558,686	2,259,455	0	2,259,455	5.04
6.00	00600	MAINTENANCE & REPAIRS	301,590	592,508	894,098	0	894,098	6.00
7.00	00700	OPERATION OF PLANT	165,863	3,511	169,374	0	169,374	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	262,551	262,551	0	262,551	8.00
9.00	00900	HOUSEKEEPING	273,601	84,311	357,912	-167	357,745	9.00
10.00	01000	DIETARY	335,167	132,542	467,709	-291,302	176,407	10.00
11.00	01100	CAFETERIA	0	0	0	290,474	290,474	11.00
13.00	01300	NURSING ADMINISTRATION	1,061,405	49,537	1,110,942	0	1,110,942	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11	518	529	0	529	14.00
15.00	01500	PHARMACY	535,040	7,335,118	7,870,158	-18,620	7,851,538	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,604	715	23,319	0	23,319	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	780,520	780,520	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,858,243	1,605,043	3,463,286	-29,019	3,434,267	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,437,334	2,686,244	4,123,578	-1,540,251	2,583,327	50.00
51.00	05100	RECOVERY ROOM	129,665	4,994	134,659	-815	133,844	51.00
53.00	05300	ANESTHESIOLOGY	221,785	808,114	1,029,899	-783,648	246,251	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	974,530	658,045	1,632,575	-42,630	1,589,945	54.00
60.00	06000	LABORATORY	723,372	1,598,158	2,321,530	-6,777	2,314,753	60.00
64.00	06400	INTRAVENOUS THERAPY	902,759	271,189	1,173,948	-11,857	1,162,091	64.00
65.00	06500	RESPIRATORY THERAPY	414,655	156,818	571,473	-53,173	518,300	65.00
65.01	03610	SLEEP LAB	651,105	336,501	987,606	0	987,606	65.01
65.02	03620	GERIATRIC PSYCH	0	418,478	418,478	0	418,478	65.02
66.00	06600	PHYSICAL THERAPY	744,574	284,289	1,028,863	0	1,028,863	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	726,069	726,069	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	892,866	892,866	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	153,240	153,240	73.00
76.97	07697	CARDIAC REHABILITATION	307,718	13,957	321,675	0	321,675	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	138,718	448,244	586,962	-44,406	542,556	90.00
91.00	09100	EMERGENCY	1,130,182	2,880,581	4,010,763	-20,504	3,990,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		463,845	463,845	-88,801	375,044	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,777,166	29,948,665	43,725,831	0	43,725,831	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	18,128	18,128	0	18,128	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	13,777,166	29,966,793	43,743,959	0	43,743,959	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	12,970	1,417,653		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,320,208	2,796,368		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,193,917	3,398,025		4.00
5.01	00550	DATA PROCESSING	2,993,363	2,993,363		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-2,374	72,414		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	707,075	1,288,947		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,102,509	4,361,964		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	894,098		6.00
7.00	00700	OPERATION OF PLANT	0	169,374		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	262,551		8.00
9.00	00900	HOUSEKEEPING	0	357,745		9.00
10.00	01000	DIETARY	0	176,407		10.00
11.00	01100	CAFETERIA	-96,378	194,096		11.00
13.00	01300	NURSING ADMINISTRATION	-2,500	1,108,442		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	529		14.00
15.00	01500	PHARMACY	0	7,851,538		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,739	10,580		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-780,520	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,119,211	2,315,056		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,583,327		50.00
51.00	05100	RECOVERY ROOM	0	133,844		51.00
53.00	05300	ANESTHESIOLOGY	0	246,251		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-44,242	1,545,703		54.00
60.00	06000	LABORATORY	-22,150	2,292,603		60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,162,091		64.00
65.00	06500	RESPIRATORY THERAPY	-4,526	513,774		65.00
65.01	03610	SLEEP LAB	-7,355	980,251		65.01
65.02	03620	GERIATRIC PSYCH	0	418,478		65.02
66.00	06600	PHYSICAL THERAPY	-190	1,028,673		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	726,069		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	892,866		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	153,240		73.00
76.97	07697	CARDIAC REHABILITATION	0	321,675		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	542,556		90.00
91.00	09100	EMERGENCY	-2,596,994	1,393,265		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-375,044	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	877,985	44,603,816		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-7,145	10,983		192.00
192.01	19201	UNUSED SPACE	0	0		192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	870,840	44,614,799		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet Non-CMS W | Date/Time Prepared: 8/22/2018 10:32 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
65.01	SLEEP LAB	03610	SLEEP LAB	65.01
65.02	GERIATRIC PSYCH	03620	STRESS TEST	65.02
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697		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	UNUSED SPACE	19201		192.01
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-6 | Date/Time Prepared: 8/22/2018 10:32 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DIETARY RECLASS					
1.00	CAFETERIA	11.00	208,527	82,462		1.00
	TOTALS		208,527	82,462		
	B - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,618,935		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
	TOTALS		0	1,618,935		
	C - IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	89,338		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		0	89,338		
	D - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	57,721		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	31,080		2.00
	TOTALS		0	88,801		
	E - CONTRAST RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	63,902		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	63,902		
	F - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	780,520		1.00
	TOTALS		0	780,520		
	G - IMPLANTABLE SUPPLY RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	892,866		1.00
	TOTALS		0	892,866		
500.00	Grand Total: Increases		208,527	3,616,824		500.00

RECLASSIFICATIONS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-6 | Date/Time Prepared: 8/22/2018 10:32 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY RECLASS						
1.00	DIETARY	10.00	208,527	82,462	0		1.00
	TOTALS		208,527	82,462			
	B - MEDICAL SUPPLY RECLASS						
1.00	OPERATING ROOM	50.00	0	1,509,833	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	77	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	40,578	0		3.00
4.00	INTRAVENOUS THERAPY	64.00	0	4,567	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	5,908	0		5.00
6.00	CLINIC	90.00	0	44,395	0		6.00
7.00	HOUSEKEEPING	9.00	0	167	0		7.00
8.00	LABORATORY	60.00	0	6,777	0		8.00
9.00	EMERGENCY	91.00	0	6,633	0		9.00
	TOTALS		0	1,618,935			
	C - IV SOLUTIONS						
1.00	DIETARY	10.00	0	313	0		1.00
2.00	CAFETERIA	11.00	0	515	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	23,111	0		3.00
4.00	OPERATING ROOM	50.00	0	20,649	0		4.00
5.00	RECOVERY ROOM	51.00	0	815	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	3,051	0		6.00
7.00	EMERGENCY	91.00	0	13,871	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	7,290	0		8.00
9.00	PHARMACY	15.00	0	18,620	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,092	0		10.00
11.00	CLINIC	90.00	0	11	0		11.00
	TOTALS		0	89,338			
	D - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	88,801	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	88,801			
	E - CONTRAST RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	41,538	0		1.00
2.00	OPERATING ROOM	50.00	0	9,769	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	12,595	0		3.00
	TOTALS		0	63,902			
	F - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	780,520	0		1.00
	TOTALS		0	780,520			
	G - IMPLANTABLE SUPPLY RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	892,866	0		1.00
	TOTALS		0	892,866			
500.00	Grand Total: Decreases		208,527	3,616,824			500.00

RECLASSIFICATIONS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 8/22/2018 10:32 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - DIETARY RECLASS								
1.00	CAFETERIA	11.00	208,527	82,462	DIETARY	10.00	208,527	82,462	1.00
	TOTALS		208,527	82,462	TOTALS		208,527	82,462	
	B - MEDICAL SUPPLY RECLASS								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,618,935	OPERATING ROOM	50.00	0	1,509,833	1.00
2.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	77	2.00
3.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	40,578	3.00
4.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	4,567	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	5,908	5.00
6.00		0.00	0	0	CLINIC	90.00	0	44,395	6.00
7.00		0.00	0	0	HOUSEKEEPING	9.00	0	167	7.00
8.00		0.00	0	0	LABORATORY	60.00	0	6,777	8.00
9.00		0.00	0	0	EMERGENCY	91.00	0	6,633	9.00
	TOTALS		0	1,618,935	TOTALS		0	1,618,935	
	C - IV SOLUTIONS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	89,338	DIETARY	10.00	0	313	1.00
2.00		0.00	0	0	CAFETERIA	11.00	0	515	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	23,111	3.00
4.00		0.00	0	0	OPERATING ROOM	50.00	0	20,649	4.00
5.00		0.00	0	0	RECOVERY ROOM	51.00	0	815	5.00
6.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	3,051	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	13,871	7.00
8.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	7,290	8.00
9.00		0.00	0	0	PHARMACY	15.00	0	18,620	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	1,092	10.00
11.00		0.00	0	0	CLINIC	90.00	0	11	11.00
	TOTALS		0	89,338	TOTALS		0	89,338	
	D - INTEREST RECLASS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	57,721	INTEREST EXPENSE	113.00	0	88,801	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	31,080		0.00	0	0	2.00
	TOTALS		0	88,801	TOTALS		0	88,801	
	E - CONTRAST RECLASS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	63,902	RADIOLOGY-DIAGNOSTIC	54.00	0	41,538	1.00
2.00		0.00	0	0	OPERATING ROOM	50.00	0	9,769	2.00
3.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	12,595	3.00
	TOTALS		0	63,902	TOTALS		0	63,902	
	F - CRNA RECLASS								
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	780,520	ANESTHESIOLOGY	53.00	0	780,520	1.00
	TOTALS		0	780,520	TOTALS		0	780,520	
	G - IMPLANTABLE SUPPLY RECLASS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	892,866	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	892,866	1.00
	TOTALS		0	892,866	TOTALS		0	892,866	
500.00	Grand Total: Increases		208,527	3,616,824	Grand Total: Decreases		208,527	3,616,824	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 8/22/2018 10:32 am

		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	171,136	0	0	0	0	1.00
2.00	Land Improvements	1,137,794	7,757	0	7,757	0	2.00
3.00	Buildings and Fixtures	15,163,505	951,481	0	951,481	0	3.00
4.00	Building Improvements	9,720,454	806,077	0	806,077	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	14,431,128	4,096,461	0	4,096,461	597,585	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,624,017	5,861,776	0	5,861,776	597,585	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	40,624,017	5,861,776	0	5,861,776	597,585	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	171,136	0	1.00
2.00	Land Improvements	1,145,551	0	2.00
3.00	Buildings and Fixtures	16,114,986	0	3.00
4.00	Building Improvements	10,526,531	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	17,930,004	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,888,208	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	45,888,208	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 8/22/2018 10:32 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,346,962	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,445,080	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,792,042	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,346,962		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,445,080		2.00
3.00	Total (sum of lines 1-2)	0	2,792,042		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 8/22/2018 10:32 am

	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	27,787,069	0	27,787,069	0.607805	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,930,004	0	17,930,004	0.392195	0	2.00
3.00	Total (sum of lines 1-2)	45,717,073	0	45,717,073	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	1,417,653	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,796,368	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,214,021	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	1,417,653	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,796,368	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,214,021	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8 | Date/Time Prepared: 8/22/2018 10:32 am

	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	-3,728,256			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	9,032,773			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-96,378	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	B	-12,739	MEDICAL RECORDS & LIBRARY	16.00	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		0		0.00	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	-780,520	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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8 | Date/Time Prepared: 8/22/2018 10:32 am

	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	PURCHASE DISCOUNTS	B	-2,374	PURCHASING RECEIVING AND STORES	5.02	0	33.00
33.01	EMPLOYEE OUTPATIENT INSURANCE PYMT	B	-2,405,715	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	LOBBYING EXPENSES	A	-13,244	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03	UNRESTRICTED INTEREST REVENUE	B	-658,810	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.03
33.04	LEASEHOLD REVENUE	B	-45,844	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	XRAY FILM REVENUE	B	-545	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	NONALLOWABLE INTEREST EXPENSE	A	-375,044	INTEREST EXPENSE	113.00	0	33.06
33.07	REAL ESTATE TAXES	A	-7,145	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.07
33.08	MEDICAID PROVIDER TAX	A	-25,184	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	CABLE TV	A	-1,834	SLEEP LAB	65.01	0	33.09
33.10	CABLE TV	A	-190	PHYSICAL THERAPY	66.00	0	33.10
33.11	MISCELLANEOUS REVENUE	B	-90	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12	REAL ESTATE TAXES	A	-5,521	SLEEP LAB	65.01	0	33.12
33.13	DEPARTMENTAL PROGRAM REVENUE	B	-2,500	NURSING ADMINISTRATION	13.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		870,840				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 8/22/2018 10:32 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	58,814	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,320,208	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,211,798	0	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	2,993,363	0	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	707,075	0	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	2,807,362	0	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	RENT	34,741	78,438	4.03
4.04	60.00	LABORATORY	RENT	17,612	39,762	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,150,973	118,200	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	HOME OFFICE	100.00	6.00
7.00	B	SIHE	100.00	RELATED ORG	100.00	7.00
8.00	B	HSSI	100.00	RELATED ORG	100.00	8.00
9.00	B	SIMS	100.00	RELATED ORG	100.00	9.00
10.00	B	SIH CAYMAN	100.00	RELATED ORG	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1334	Period: From 04/01/2017 To 03/31/2018	Worksheet A-8-1 Date/Time Prepared: 8/22/2018 10:32 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	58,814	9		1.00
2.00	1,320,208	9		2.00
3.00	1,211,798	0		3.00
4.00	2,993,363	0		4.00
4.01	707,075	0		4.01
4.02	2,807,362	0		4.02
4.03	-43,697	0		4.03
4.04	-22,150	0		4.04
5.00	9,032,773			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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 8/22/2018 10:32 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	DR. A	2,596,994	2,596,994	0	0	0	1.00
2.00	60.00	DR. B	175,046	0	175,046	0	0	2.00
3.00	76.97	DR. C	2,585	0	2,585	0	0	3.00
4.00	65.01	DR. D	20,166	0	20,166	0	0	4.00
5.00	65.00	DR. E	4,526	4,526	0	0	0	5.00
6.00	30.00	DR. F	1,119,211	1,119,211	0	0	0	6.00
7.00	5.04	DR. G	7,525	7,525	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,926,053	3,728,256	197,797		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	DR. A	0	0	0	0	0	1.00
2.00	60.00	DR. B	0	0	0	0	0	2.00
3.00	76.97	DR. C	0	0	0	0	0	3.00
4.00	65.01	DR. D	0	0	0	0	0	4.00
5.00	65.00	DR. E	0	0	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	5.04	DR. G	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	DR. A	0	0	0	2,596,994		1.00
2.00	60.00	DR. B	0	0	0	0		2.00
3.00	76.97	DR. C	0	0	0	0		3.00
4.00	65.01	DR. D	0	0	0	0		4.00
5.00	65.00	DR. E	0	0	0	4,526		5.00
6.00	30.00	DR. F	0	0	0	1,119,211		6.00
7.00	5.04	DR. G	0	0	0	7,525		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,728,256		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,417,653	1,417,653				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,796,368		2,796,368			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,398,025	13,247	26,129	3,437,401		4.00
5.01	00550	DATA PROCESSING	2,993,363	6,317	12,460	0	3,012,140	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	72,414	6,244	12,317	8,837	8,252	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,288,947	19,461	38,388	141,495	99,029	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	4,361,964	281,111	554,502	176,773	346,602	5.04
6.00	00600	MAINTENANCE & REPAIRS	894,098	124,515	245,611	76,078	148,544	6.00
7.00	00700	OPERATION OF PLANT	169,374	20,045	39,539	41,840	8,252	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	262,551	9,833	19,396	0	0	8.00
9.00	00900	HOUSEKEEPING	357,745	9,556	18,849	69,017	24,757	9.00
10.00	01000	DIETARY	176,407	68,903	135,913	31,945	41,262	10.00
11.00	01100	CAFETERIA	194,096	6,857	13,525	52,602	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,108,442	33,540	66,158	267,746	57,767	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	529	6,813	13,439	3	0	14.00
15.00	01500	PHARMACY	7,851,538	13,509	26,647	134,967	41,262	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,580	67,911	133,957	5,702	33,010	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,315,056	123,494	243,597	468,754	264,078	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,583,327	187,904	370,647	362,576	495,149	50.00
51.00	05100	RECOVERY ROOM	133,844	20,731	40,892	32,709	24,757	51.00
53.00	05300	ANESTHESIOLOGY	246,251	1,138	2,245	55,947	82,524	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,545,703	74,345	146,647	245,831	165,049	54.00
60.00	06000	LABORATORY	2,292,603	34,255	67,568	182,475	140,291	60.00
64.00	06400	INTRAVENOUS THERAPY	1,162,091	40,557	80,000	227,726	99,029	64.00
65.00	06500	RESPIRATORY THERAPY	513,774	9,585	18,906	104,599	74,272	65.00
65.01	03610	SLEEP LAB	980,251	42,264	83,367	164,245	387,865	65.01
65.02	03620	GERIATRIC PSYCH	418,478	17,652	34,820	0	41,262	65.02
66.00	06600	PHYSICAL THERAPY	1,028,673	17,507	34,532	187,823	140,291	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	726,069	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	892,866	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	153,240	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	321,675	27,602	54,446	77,624	57,767	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	542,556	37,274	73,525	34,992	107,282	90.00
91.00	09100	EMERGENCY	1,393,265	69,253	136,604	285,095	123,787	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)	44,603,816	1,391,423	2,744,626	3,437,401	3,012,140	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,375	12,576	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,983	12,969	25,583	0	0	192.00
192.01	19201	UNUSED SPACE	0	6,886	13,583	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	44,614,799	1,417,653	2,796,368	3,437,401	3,012,140	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	108,064					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,197	1,588,517				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1	0	5,720,953	5,720,953		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,488,846	218,996	1,707,842	6.00
7.00	00700	OPERATION OF PLANT	0	0	279,050	41,046	35,411	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	291,780	42,918	17,370	8.00
9.00	00900	HOUSEKEEPING	684	0	480,608	70,693	16,881	9.00
10.00	01000	DIETARY	38	0	454,468	66,848	121,722	10.00
11.00	01100	CAFETERIA	63	0	267,143	39,294	12,113	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,533,653	225,587	59,250	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40	0	20,824	3,063	12,036	14.00
15.00	01500	PHARMACY	1,783	0	8,069,706	1,187,000	23,865	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	251,160	36,943	119,969	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,532	28,812	3,458,323	508,688	218,161	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,118	275,119	4,316,840	634,968	331,946	50.00
51.00	05100	RECOVERY ROOM	202	68,647	321,782	47,331	36,622	51.00
53.00	05300	ANESTHESIOLOGY	1,356	43,470	432,931	63,680	2,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,538	306,993	2,489,106	366,125	131,335	54.00
60.00	06000	LABORATORY	5,487	260,480	2,983,159	438,796	60,513	60.00
64.00	06400	INTRAVENOUS THERAPY	19,769	35,383	1,664,555	244,841	71,647	64.00
65.00	06500	RESPIRATORY THERAPY	1,185	33,534	755,855	111,179	16,932	65.00
65.01	03610	SLEEP LAB	686	81,764	1,740,442	256,003	74,662	65.01
65.02	03620	GERIATRIC PSYCH	1	5,858	518,071	76,204	31,184	65.02
66.00	06600	PHYSICAL THERAPY	439	46,885	1,456,150	214,187	30,927	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,478	758,547	111,575	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,803	915,669	134,687	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	202,463	355,703	52,321	0	73.00
76.97	07697	CARDIAC REHABILITATION	226	11,801	551,141	81,068	48,761	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,146	35,294	833,069	122,537	65,848	90.00
91.00	09100	EMERGENCY	11,573	96,733	2,116,310	311,290	122,340	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)	108,064	1,588,517	44,525,844	5,707,868	1,661,505	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,951	2,788	11,262	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	49,535	7,286	22,911	192.00
192.01	19201	UNUSED SPACE	0	0	20,469	3,011	12,164	192.01
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	108,064	1,588,517	44,614,799	5,720,953	1,707,842	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	355,507					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,692	355,760				8.00
9.00	00900	HOUSEKEEPING	3,588	240	572,010			9.00
10.00	01000	DIETARY	25,874	372	1,274	670,558		10.00
11.00	01100	CAFETERIA	2,575	0	5,945	0	327,070	11.00
13.00	01300	NURSING ADMINISTRATION	12,595	0	0	0	24,159	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,558	0	0	0	0	14.00
15.00	01500	PHARMACY	5,073	0	3,397	0	11,150	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,502	0	1,168	0	1,858	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,374	128,241	247,679	670,558	59,466	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,562	68,487	82,383	0	42,742	50.00
51.00	05100	RECOVERY ROOM	7,785	23,567	3,822	0	3,717	51.00
53.00	05300	ANESTHESIOLOGY	427	0	2,017	0	5,575	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,918	19,867	24,099	0	31,592	54.00
60.00	06000	LABORATORY	12,863	0	15,925	0	26,017	60.00
64.00	06400	INTRAVENOUS THERAPY	15,230	0	16,986	0	26,017	64.00
65.00	06500	RESPIRATORY THERAPY	3,599	572	3,822	0	9,292	65.00
65.01	03610	SLEEP LAB	15,871	2,273	43,315	0	20,442	65.01
65.02	03620	GERIATRIC PSYCH	6,629	0	6,370	0	0	65.02
66.00	06600	PHYSICAL THERAPY	6,574	0	0	0	20,442	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	10,365	1,203	10,404	0	9,292	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,997	14,856	53,082	0	3,717	90.00
91.00	09100	EMERGENCY	26,006	96,082	50,322	0	31,592	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)	345,657	355,760	572,010	670,558	327,070	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,394	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,870	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	2,586	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	355,507	355,760	572,010	670,558	327,070	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,855,244					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	38,481				14.00
15.00	01500	PHARMACY	137,971	0	9,438,162			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	436,600		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	741,946	303	32,235	7,920	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	536,789	35,041	30,075	75,626	0	50.00
51.00	05100	RECOVERY ROOM	43,523	0	1,085	18,870	0	51.00
53.00	05300	ANESTHESIOLOGY	0	4	4,363	11,949	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,454	84,329	0	54.00
60.00	06000	LABORATORY	0	359	0	71,602	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	242	30,583	9,726	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,151	0	9,218	0	65.00
65.01	03610	SLEEP LAB	0	0	0	22,476	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	1,610	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	1,048	12,888	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,928	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,268	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	9,311,101	55,654	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	3,244	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	100	6,075	9,702	0	90.00
91.00	09100	EMERGENCY	395,015	281	20,143	26,590	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)	1,855,244	38,481	9,438,162	436,600	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,855,244	38,481	9,438,162	436,600	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,119,894	0	6,119,894		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,225,459	0	6,225,459		50.00
51.00	05100	RECOVERY ROOM	508,104	0	508,104		51.00
53.00	05300	ANESTHESIOLOGY	522,956	0	522,956		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,175,825	0	3,175,825		54.00
60.00	06000	LABORATORY	3,609,234	0	3,609,234		60.00
64.00	06400	INTRAVENOUS THERAPY	2,079,827	0	2,079,827		64.00
65.00	06500	RESPIRATORY THERAPY	912,620	0	912,620		65.00
65.01	03610	SLEEP LAB	2,175,484	0	2,175,484		65.01
65.02	03620	GERIATRIC PSYCH	640,068	0	640,068		65.02
66.00	06600	PHYSICAL THERAPY	1,742,216	0	1,742,216		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	879,050	0	879,050		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,056,624	0	1,056,624		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,774,779	0	9,774,779		73.00
76.97	07697	CARDIAC REHABILITATION	715,478	0	715,478		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,122,983	0	1,122,983		90.00
91.00	09100	EMERGENCY	3,195,971	0	3,195,971		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)	44,456,572	0	44,456,572		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,395	0	35,395		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	84,602	0	84,602		192.00
192.01	19201	UNUSED SPACE	38,230	0	38,230		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	44,614,799	0	44,614,799		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet Non-CMS W | Date/Time Prepared: 8/22/2018 10:32 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	24	# OF PC'S	5.01
5.02	PURCHASING RECEIVING AND STORES	25	PURCHASED SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	16	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	# OF FTE'S	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II Date/Time Prepared: 8/22/2018 10:32 am

		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	13,247	26,129	39,376	39,376	4.00
5.01	00550	DATA PROCESSING	0	6,317	12,460	18,777	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	6,244	12,317	18,561	101	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	19,461	38,388	57,849	1,621	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	281,111	554,502	835,613	2,025	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	124,515	245,611	370,126	872	6.00
7.00	00700	OPERATION OF PLANT	0	20,045	39,539	59,584	479	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,833	19,396	29,229	0	8.00
9.00	00900	HOUSEKEEPING	0	9,556	18,849	28,405	791	9.00
10.00	01000	DIETARY	0	68,903	135,913	204,816	366	10.00
11.00	01100	CAFETERIA	0	6,857	13,525	20,382	603	11.00
13.00	01300	NURSING ADMINISTRATION	0	33,540	66,158	99,698	3,067	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,813	13,439	20,252	0	14.00
15.00	01500	PHARMACY	0	13,509	26,647	40,156	1,546	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	67,911	133,957	201,868	65	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	123,494	243,597	367,091	5,366	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	187,904	370,647	558,551	4,154	50.00
51.00	05100	RECOVERY ROOM	0	20,731	40,892	61,623	375	51.00
53.00	05300	ANESTHESIOLOGY	0	1,138	2,245	3,383	641	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	74,345	146,647	220,992	2,816	54.00
60.00	06000	LABORATORY	0	34,255	67,568	101,823	2,091	60.00
64.00	06400	INTRAVENOUS THERAPY	0	40,557	80,000	120,557	2,609	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,585	18,906	28,491	1,198	65.00
65.01	03610	SLEEP LAB	0	42,264	83,367	125,631	1,882	65.01
65.02	03620	GERIATRIC PSYCH	0	17,652	34,820	52,472	0	65.02
66.00	06600	PHYSICAL THERAPY	0	17,507	34,532	52,039	2,152	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	27,602	54,446	82,048	889	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	37,274	73,525	110,799	401	90.00
91.00	09100	EMERGENCY	0	69,253	136,604	205,857	3,266	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	1,391,423	2,744,626	4,136,049	39,376	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,375	12,576	18,951	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,969	25,583	38,552	0	192.00
192.01	19201	UNUSED SPACE	0	6,886	13,583	20,469	0	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,417,653	2,796,368	4,214,021	39,376	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II Date/Time Prepared: 8/22/2018 10:32 am

		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	18,777					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	51	18,713				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	617	207	60,294			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,161	0	0	839,799		5.04
6.00	00600	MAINTENANCE & REPAIRS	926	0	0	32,147	404,071	6.00
7.00	00700	OPERATION OF PLANT	51	0	0	6,025	8,378	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	6,300	4,110	8.00
9.00	00900	HOUSEKEEPING	154	118	0	10,377	3,994	9.00
10.00	01000	DIETARY	257	7	0	9,813	28,799	10.00
11.00	01100	CAFETERIA	0	11	0	5,768	2,866	11.00
13.00	01300	NURSING ADMINISTRATION	360	0	0	33,115	14,018	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7	0	450	2,848	14.00
15.00	01500	PHARMACY	257	309	0	174,245	5,646	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	206	0	0	5,423	28,384	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,646	2,516	1,094	74,672	51,616	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,088	7,294	10,444	93,209	78,539	50.00
51.00	05100	RECOVERY ROOM	154	35	2,606	6,948	8,665	51.00
53.00	05300	ANESTHESIOLOGY	514	235	1,650	9,348	476	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,029	786	11,644	53,745	31,073	54.00
60.00	06000	LABORATORY	875	950	9,889	64,412	14,317	60.00
64.00	06400	INTRAVENOUS THERAPY	617	3,423	1,343	35,941	16,951	64.00
65.00	06500	RESPIRATORY THERAPY	463	205	1,273	16,320	4,006	65.00
65.01	03610	SLEEP LAB	2,418	119	3,104	37,580	17,665	65.01
65.02	03620	GERIATRIC PSYCH	257	0	222	11,186	7,378	65.02
66.00	06600	PHYSICAL THERAPY	875	76	1,780	31,441	7,317	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,233	16,379	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	866	19,771	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,686	7,680	0	73.00
76.97	07697	CARDIAC REHABILITATION	360	39	448	11,900	11,537	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	669	372	1,340	17,988	15,579	90.00
91.00	09100	EMERGENCY	772	2,004	3,672	45,695	28,945	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)	18,777	18,713	60,294	837,878	393,107	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	409	2,665	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,070	5,421	192.00
192.01	19201	UNUSED SPACE	0	0	0	442	2,878	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,777	18,713	60,294	839,799	404,071	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	74,517					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	774	40,413				8.00
9.00	00900	HOUSEKEEPING	752	27	44,618			9.00
10.00	01000	DIETARY	5,423	42	99	249,622		10.00
11.00	01100	CAFETERIA	540	0	464	0	30,634	11.00
13.00	01300	NURSING ADMINISTRATION	2,640	0	0	0	2,263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	536	0	0	0	0	14.00
15.00	01500	PHARMACY	1,063	0	265	0	1,044	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,345	0	91	0	174	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,720	14,567	19,320	249,622	5,570	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,791	7,780	6,426	0	4,003	50.00
51.00	05100	RECOVERY ROOM	1,632	2,677	298	0	348	51.00
53.00	05300	ANESTHESIOLOGY	90	0	157	0	522	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,852	2,257	1,880	0	2,959	54.00
60.00	06000	LABORATORY	2,696	0	1,242	0	2,437	60.00
64.00	06400	INTRAVENOUS THERAPY	3,192	0	1,325	0	2,437	64.00
65.00	06500	RESPIRATORY THERAPY	754	65	298	0	870	65.00
65.01	03610	SLEEP LAB	3,327	258	3,379	0	1,915	65.01
65.02	03620	GERIATRIC PSYCH	1,389	0	497	0	0	65.02
66.00	06600	PHYSICAL THERAPY	1,378	0	0	0	1,915	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,173	137	812	0	870	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,934	1,688	4,140	0	348	90.00
91.00	09100	EMERGENCY	5,451	10,915	3,925	0	2,959	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)	72,452	40,413	44,618	249,622	30,634	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	502	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,021	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	542	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	74,517	40,413	44,618	249,622	30,634	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	155,161					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,093				14.00
15.00	01500	PHARMACY	11,539	0	236,070			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	241,556		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,051	189	806	4,382		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,894	21,939	752	41,841		50.00
51.00	05100	RECOVERY ROOM	3,640	0	27	10,440		51.00
53.00	05300	ANESTHESIOLOGY	0	3	109	6,611		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	36	46,658		54.00
60.00	06000	LABORATORY	0	225	0	39,615		60.00
64.00	06400	INTRAVENOUS THERAPY	0	152	765	5,381		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,347	0	5,100		65.00
65.01	03610	SLEEP LAB	0	0	0	12,435		65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	891		65.02
66.00	06600	PHYSICAL THERAPY	0	0	26	7,130		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,939		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,468		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	232,893	30,791		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,795		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	62	152	5,368		90.00
91.00	09100	EMERGENCY	33,037	176	504	14,711		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)	155,161	24,093	236,070	241,556	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	UNUSED SPACE	0	0	0	0		192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	155,161	24,093	236,070	241,556	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	870,228	0	870,228		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	897,705	0	897,705		50.00
51.00	05100	RECOVERY ROOM	99,468	0	99,468		51.00
53.00	05300	ANESTHESIOLOGY	23,739	0	23,739		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	381,727	0	381,727		54.00
60.00	06000	LABORATORY	240,572	0	240,572		60.00
64.00	06400	INTRAVENOUS THERAPY	194,693	0	194,693		64.00
65.00	06500	RESPIRATORY THERAPY	60,390	0	60,390		65.00
65.01	03610	SLEEP LAB	209,713	0	209,713		65.01
65.02	03620	GERIATRIC PSYCH	74,292	0	74,292		65.02
66.00	06600	PHYSICAL THERAPY	106,129	0	106,129		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,551	0	22,551		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,105	0	24,105		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	279,050	0	279,050		73.00
76.97	07697	CARDIAC REHABILITATION	113,008	0	113,008		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	161,840	0	161,840		90.00
91.00	09100	EMERGENCY	361,889	0	361,889		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)	4,121,099	0	4,121,099		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,527	0	22,527		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	46,064	0	46,064		192.00
192.01	19201	UNUSED SPACE	24,331	0	24,331		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	4,214,021	0	4,214,021		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (# OF PC'S)	PURCHASING RECEIVING AND STORES (PURCHASED SUPPLIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,174					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		97,174				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	908	908	13,626,640			4.00
5.01	00550	DATA PROCESSING	433	433	0	365		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	428	428	35,031	1	1,249,249	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,334	1,334	560,920	12	13,834	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	19,269	19,269	700,769	42	16	5.04
6.00	00600	MAINTENANCE & REPAIRS	8,535	8,535	301,590	18	0	6.00
7.00	00700	OPERATION OF PLANT	1,374	1,374	165,863	1	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	674	674	0	0	0	8.00
9.00	00900	HOUSEKEEPING	655	655	273,601	3	7,906	9.00
10.00	01000	DIETARY	4,723	4,723	126,639	5	444	10.00
11.00	01100	CAFETERIA	470	470	208,527	0	732	11.00
13.00	01300	NURSING ADMINISTRATION	2,299	2,299	1,061,405	7	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	467	467	11	0	458	14.00
15.00	01500	PHARMACY	926	926	535,040	5	20,614	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,655	4,655	22,604	4	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	8,465	8,465	1,858,243	32	167,999	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,880	12,880	1,437,334	60	486,868	50.00
51.00	05100	RECOVERY ROOM	1,421	1,421	129,665	3	2,339	51.00
53.00	05300	ANESTHESIOLOGY	78	78	221,785	10	15,679	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,096	5,096	974,530	20	52,458	54.00
60.00	06000	LABORATORY	2,348	2,348	723,372	17	63,435	60.00
64.00	06400	INTRAVENOUS THERAPY	2,780	2,780	902,759	12	228,534	64.00
65.00	06500	RESPIRATORY THERAPY	657	657	414,655	9	13,697	65.00
65.01	03610	SLEEP LAB	2,897	2,897	651,105	47	7,932	65.01
65.02	03620	GERIATRIC PSYCH	1,210	1,210	0	5	14	65.02
66.00	06600	PHYSICAL THERAPY	1,200	1,200	744,574	17	5,076	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,892	1,892	307,718	7	2,618	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,555	2,555	138,718	13	24,803	90.00
91.00	09100	EMERGENCY	4,747	4,747	1,130,182	15	133,793	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)	95,376	95,376	13,626,640	365	1,249,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	437	437	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	889	889	0	0	0	192.00
192.01	19201	UNUSED SPACE	472	472	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,417,653	2,796,368	3,437,401	3,012,140	108,064	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.588810	28.776916	0.252256	8,252.438356	0.086503	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			39,376	18,777	18,713	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002890	51.443836	0.014979	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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5A.04	5.04	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	183,846,903					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-5,720,953	38,893,846			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,488,846	66,267		6.00
7.00	00700	OPERATION OF PLANT	0	0	279,050	1,374	64,893	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	291,780	674	674	8.00
9.00	00900	HOUSEKEEPING	0	0	480,608	655	655	9.00
10.00	01000	DIETARY	0	0	454,468	4,723	4,723	10.00
11.00	01100	CAFETERIA	0	0	267,143	470	470	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,533,653	2,299	2,299	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	20,824	467	467	14.00
15.00	01500	PHARMACY	0	0	8,069,706	926	926	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	251,160	4,655	4,655	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,334,699	0	3,458,323	8,465	8,465	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,842,479	0	4,316,840	12,880	12,880	50.00
51.00	05100	RECOVERY ROOM	7,945,235	0	321,782	1,421	1,421	51.00
53.00	05300	ANESTHESIOLOGY	5,031,212	0	432,931	78	78	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,522,360	0	2,489,106	5,096	5,096	54.00
60.00	06000	LABORATORY	30,148,121	0	2,983,159	2,348	2,348	60.00
64.00	06400	INTRAVENOUS THERAPY	4,095,293	0	1,664,555	2,780	2,780	64.00
65.00	06500	RESPIRATORY THERAPY	3,881,256	0	755,855	657	657	65.00
65.01	03610	SLEEP LAB	9,463,432	0	1,740,442	2,897	2,897	65.01
65.02	03620	GERIATRIC PSYCH	678,030	0	518,071	1,210	1,210	65.02
66.00	06600	PHYSICAL THERAPY	5,426,463	0	1,456,150	1,200	1,200	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,759,072	0	758,547	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,639,251	0	915,669	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,433,273	0	355,703	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,365,829	0	551,141	1,892	1,892	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,085,006	0	833,069	2,555	2,555	90.00
91.00	09100	EMERGENCY	11,195,892	0	2,116,310	4,747	4,747	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)	183,846,903	-5,720,953	38,804,891	64,469	63,095	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,951	437	437	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	49,535	889	889	192.00
192.01	19201	UNUSED SPACE	0	0	20,469	472	472	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,588,517		5,720,953	1,707,842	355,507	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008640		0.147091	25.772134	5.478357	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	60,294		839,799	404,071	74,517	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000328		0.021592	6.097620	1.148306	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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (# OF FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,776					8.00
9.00	00900	HOUSEKEEPING	49	5,388				9.00
10.00	01000	DIETARY	76	12	18,691			10.00
11.00	01100	CAFETERIA	0	56	0	176		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	13	165,904	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	32	0	6	12,338	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11	0	1	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,234	2,333	18,691	32	66,348	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,010	776	0	23	48,002	50.00
51.00	05100	RECOVERY ROOM	4,821	36	0	2	3,892	51.00
53.00	05300	ANESTHESIOLOGY	0	19	0	3	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,064	227	0	17	0	54.00
60.00	06000	LABORATORY	0	150	0	14	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	160	0	14	0	64.00
65.00	06500	RESPIRATORY THERAPY	117	36	0	5	0	65.00
65.01	03610	SLEEP LAB	465	408	0	11	0	65.01
65.02	03620	GERIATRIC PSYCH	0	60	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	11	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	246	98	0	5	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,039	500	0	2	0	90.00
91.00	09100	EMERGENCY	19,655	474	0	17	35,324	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)	72,776	5,388	18,691	176	165,904	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	355,760	572,010	670,558	327,070	1,855,244	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.888425	106.163697	35.875983	1,858.352273	11.182636	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,413	44,618	249,622	30,634	155,161	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.555307	8.280995	13.355198	174.056818	0.935246	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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/22/2018 10:32 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	725,902					14.00
15.00	01500	PHARMACY	0	7,087,236				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	183,846,903			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,709	24,206	3,334,699	0		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	661,017	22,584	31,842,479	0		50.00
51.00	05100	RECOVERY ROOM	0	815	7,945,235	0		51.00
53.00	05300	ANESTHESIOLOGY	77	3,276	5,031,212	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,092	35,522,360	0		54.00
60.00	06000	LABORATORY	6,777	0	30,148,121	0		60.00
64.00	06400	INTRAVENOUS THERAPY	4,567	22,965	4,095,293	0		64.00
65.00	06500	RESPIRATORY THERAPY	40,578	0	3,881,256	0		65.00
65.01	03610	SLEEP LAB	0	0	9,463,432	0		65.01
65.02	03620	GERIATRIC PSYCH	0	0	678,030	0		65.02
66.00	06600	PHYSICAL THERAPY	0	787	5,426,463	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,759,072	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,639,251	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,991,823	23,433,273	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	1,365,829	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,881	4,562	4,085,006	0		90.00
91.00	09100	EMERGENCY	5,296	15,126	11,195,892	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)	725,902	7,087,236	183,846,903	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	UNUSED SPACE	0	0	0	0		192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	38,481	9,438,162	436,600	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.053011	1.331713	0.002375	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,093	236,070	241,556	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.033190	0.033309	0.001314	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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,119,894		6,119,894	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,225,459		6,225,459	0	0	50.00
51.00	05100	RECOVERY ROOM	508,104		508,104	0	0	51.00
53.00	05300	ANESTHESIOLOGY	522,956		522,956	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,175,825		3,175,825	0	0	54.00
60.00	06000	LABORATORY	3,609,234		3,609,234	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,079,827		2,079,827	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	912,620	0	912,620	0	0	65.00
65.01	03610	SLEEP LAB	2,175,484	0	2,175,484	0	0	65.01
65.02	03620	GERIATRIC PSYCH	640,068	0	640,068	0	0	65.02
66.00	06600	PHYSICAL THERAPY	1,742,216	0	1,742,216	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	879,050		879,050	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,056,624		1,056,624	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,774,779		9,774,779	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	715,478		715,478	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,122,983		1,122,983	0	0	90.00
91.00	09100	EMERGENCY	3,195,971		3,195,971	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	404,901		404,901		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	44,861,473	0	44,861,473	0	0	200.00
201.00		Less Observation Beds	404,901		404,901		0	201.00
202.00		Total (see instructions)	44,456,572	0	44,456,572	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | 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	2,832,236		2,832,236			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	481,809	30,400,150	30,881,959	0.201589	0.000000	50.00
51.00	05100	RECOVERY ROOM	64,132	7,587,576	7,651,708	0.066404	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	83,978	4,741,333	4,825,311	0.108378	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,125,037	33,424,874	34,549,911	0.091920	0.000000	54.00
60.00	06000	LABORATORY	1,745,380	27,105,139	28,850,519	0.125101	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	122,568	3,972,725	4,095,293	0.507858	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,058,677	2,706,008	3,764,685	0.242416	0.000000	65.00
65.01	03610	SLEEP LAB	0	8,978,418	8,978,418	0.242301	0.000000	65.01
65.02	03620	GERIATRIC PSYCH	0	678,030	678,030	0.944011	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	1,651,892	3,575,595	5,227,487	0.333280	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,241	3,525,805	3,665,046	0.239847	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,251	2,539,606	2,582,857	0.409091	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,554,264	20,452,639	23,006,903	0.424863	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,360,837	1,360,837	0.525763	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,272	4,067,605	4,074,877	0.275587	0.000000	90.00
91.00	09100	EMERGENCY	257,417	10,759,770	11,017,187	0.290090	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	20,989	458,586	479,575	0.844291	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,188,143	166,334,696	178,522,839			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,188,143	166,334,696	178,522,839			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	03610	SLEEP LAB	0.000000		65.01
65.02	03620	GERIATRIC PSYCH	0.000000		65.02
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 10:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,119,894		6,119,894	0	6,119,894	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,225,459		6,225,459	0	6,225,459	50.00
51.00	05100	RECOVERY ROOM	508,104		508,104	0	508,104	51.00
53.00	05300	ANESTHESIOLOGY	522,956		522,956	0	522,956	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,175,825		3,175,825	0	3,175,825	54.00
60.00	06000	LABORATORY	3,609,234		3,609,234	0	3,609,234	60.00
64.00	06400	INTRAVENOUS THERAPY	2,079,827		2,079,827	0	2,079,827	64.00
65.00	06500	RESPIRATORY THERAPY	912,620	0	912,620	0	912,620	65.00
65.01	03610	SLEEP LAB	2,175,484	0	2,175,484	0	2,175,484	65.01
65.02	03620	GERIATRIC PSYCH	640,068	0	640,068	0	640,068	65.02
66.00	06600	PHYSICAL THERAPY	1,742,216	0	1,742,216	0	1,742,216	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	879,050		879,050	0	879,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,056,624		1,056,624	0	1,056,624	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,774,779		9,774,779	0	9,774,779	73.00
76.97	07697	CARDIAC REHABILITATION	715,478		715,478	0	715,478	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,122,983		1,122,983	0	1,122,983	90.00
91.00	09100	EMERGENCY	3,195,971		3,195,971	0	3,195,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	404,901		404,901		404,901	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	44,861,473	0	44,861,473	0	44,861,473	200.00
201.00		Less Observation Beds	404,901		404,901		404,901	201.00
202.00		Total (see instructions)	44,456,572	0	44,456,572	0	44,456,572	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 10:32 am

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	2,832,236		2,832,236			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	481,809	30,400,150	30,881,959	0.201589	0.000000	50.00
51.00	05100	RECOVERY ROOM	64,132	7,587,576	7,651,708	0.066404	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	83,978	4,741,333	4,825,311	0.108378	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,125,037	33,424,874	34,549,911	0.091920	0.000000	54.00
60.00	06000	LABORATORY	1,745,380	27,105,139	28,850,519	0.125101	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	122,568	3,972,725	4,095,293	0.507858	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,058,677	2,706,008	3,764,685	0.242416	0.000000	65.00
65.01	03610	SLEEP LAB	0	8,978,418	8,978,418	0.242301	0.000000	65.01
65.02	03620	GERIATRIC PSYCH	0	678,030	678,030	0.944011	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	1,651,892	3,575,595	5,227,487	0.333280	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,241	3,525,805	3,665,046	0.239847	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,251	2,539,606	2,582,857	0.409091	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,554,264	20,452,639	23,006,903	0.424863	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,360,837	1,360,837	0.525763	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,272	4,067,605	4,074,877	0.275587	0.000000	90.00
91.00	09100	EMERGENCY	257,417	10,759,770	11,017,187	0.290090	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	20,989	458,586	479,575	0.844291	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,188,143	166,334,696	178,522,839			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,188,143	166,334,696	178,522,839			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/22/2018 10:32 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	03610	SLEEP LAB	0.000000		65.01
65.02	03620	GERIATRIC PSYCH	0.000000		65.02
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part II Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	897,705	30,881,959	0.029069	307,855	8,949	50.00
51.00	05100	RECOVERY ROOM	99,468	7,651,708	0.012999	51,341	667	51.00
53.00	05300	ANESTHESIOLOGY	23,739	4,825,311	0.004920	49,257	242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	381,727	34,549,911	0.011049	578,857	6,396	54.00
60.00	06000	LABORATORY	240,572	28,850,519	0.008339	657,034	5,479	60.00
64.00	06400	INTRAVENOUS THERAPY	194,693	4,095,293	0.047541	50,702	2,410	64.00
65.00	06500	RESPIRATORY THERAPY	60,390	3,764,685	0.016041	257,205	4,126	65.00
65.01	03610	SLEEP LAB	209,713	8,978,418	0.023357	0	0	65.01
65.02	03620	GERIATRIC PSYCH	74,292	678,030	0.109570	0	0	65.02
66.00	06600	PHYSICAL THERAPY	106,129	5,227,487	0.020302	121,172	2,460	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,551	3,665,046	0.006153	98,106	604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,105	2,582,857	0.009333	9,701	91	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	279,050	23,006,903	0.012129	692,688	8,402	73.00
76.97	07697	CARDIAC REHABILITATION	113,008	1,360,837	0.083043	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	161,840	4,074,877	0.039717	4,632	184	90.00
91.00	09100	EMERGENCY	361,889	11,017,187	0.032848	6,800	223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	57,576	479,575	0.120056	1,250	150	92.00
200.00		Total (lines 50 through 199)	3,308,447	175,690,603		2,886,600	40,383	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | 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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | 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	30,881,959	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,651,708	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,825,311	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,549,911	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	28,850,519	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	4,095,293	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,764,685	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	8,978,418	0.000000	65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	678,030	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	5,227,487	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,665,046	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,582,857	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,006,903	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,360,837	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4,074,877	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	11,017,187	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	479,575	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	175,690,603		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | 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	307,855	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	51,341	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	49,257	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	578,857	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	657,034	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	50,702	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	257,205	0	0	0	65.00
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0.000000	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.000000	121,172	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	98,106	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	9,701	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	692,688	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	4,632	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	6,800	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,250	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,886,600	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | 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
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03610	SLEEP LAB	0	0		65.01
65.02	03620	GERIATRIC PSYCH	0	0		65.02
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.201589	0	9,081,924	0	0	50.00
51.00	05100	RECOVERY ROOM	0.066404	0	2,465,415	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.108378	0	1,476,708	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091920	0	11,026,395	0	0	54.00
60.00	06000	LABORATORY	0.125101	0	8,770,715	3,689	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.507858	0	1,707,127	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.242416	0	861,896	0	0	65.00
65.01	03610	SLEEP LAB	0.242301	0	2,327,588	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0.944011	0	582,916	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.333280	0	1,048,019	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239847	0	1,457,114	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.409091	0	901,362	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.424863	0	9,732,858	1,328	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.525763	0	583,746	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.275587	0	2,489,544	0	0	90.00
91.00	09100	EMERGENCY	0.290090	0	2,973,444	1,584	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.844291	0	327,711	0	0	92.00
200.00		Subtotal (see instructions)		0	57,814,482	6,601	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	57,814,482	6,601	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Hospital | Cost

		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	1,830,816	0		50.00
51.00	05100	RECOVERY ROOM	163,713	0		51.00
53.00	05300	ANESTHESIOLOGY	160,043	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,013,546	0		54.00
60.00	06000	LABORATORY	1,097,225	461		60.00
64.00	06400	INTRAVENOUS THERAPY	866,978	0		64.00
65.00	06500	RESPIRATORY THERAPY	208,937	0		65.00
65.01	03610	SLEEP LAB	563,977	0		65.01
65.02	03620	GERIATRIC PSYCH	550,279	0		65.02
66.00	06600	PHYSICAL THERAPY	349,284	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	349,484	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	368,739	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,135,131	564		73.00
76.97	07697	CARDIAC REHABILITATION	306,912	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	686,086	0		90.00
91.00	09100	EMERGENCY	862,566	460		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	276,683	0		92.00
200.00		Subtotal (see instructions)	13,790,399	1,485		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	13,790,399	1,485		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.201589	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.066404	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.108378	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091920	0	0	0	0	54.00
60.00	06000	LABORATORY	0.125101	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.507858	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.242416	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0.242301	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0.944011	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.333280	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239847	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.409091	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.424863	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.525763	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.275587	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.290090	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.844291	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V | Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Swing Beds - SNF | Cost

		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
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03610	SLEEP LAB	0	0		65.01
65.02	03620	GERIATRIC PSYCH	0	0		65.02
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1334	Period: From 04/01/2017 To 03/31/2018	Worksheet D-1 Date/Time Prepared: 8/22/2018 10:32 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,104	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,716	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,404	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	2,241	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)	707	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	347	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)	93	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	845	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	1,595	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)	544	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	152.66	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	152.66	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,119,894	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)	52,973	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)	14,197	25.00
26.00	Total swing-bed cost (see instructions)	3,892,937	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,226,957	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)	2,226,957	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)	1,297.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,096,599	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)	1,096,599	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	660,798	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,757,397	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	2,069,911	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	705,976	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,775,887	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)	312	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,297.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	404,901	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	870,228	6,119,894	0.142197	404,901	57,576	90.00
91.00	Nursing School cost	0	6,119,894	0.000000	404,901	0	91.00
92.00	Allied health cost	0	6,119,894	0.000000	404,901	0	92.00
93.00	All other Medical Education	0	6,119,894	0.000000	404,901	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-3 | Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		685,942		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.201589	307,855	62,060	50.00
51.00	05100	RECOVERY ROOM	0.066404	51,341	3,409	51.00
53.00	05300	ANESTHESIOLOGY	0.108378	49,257	5,338	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091920	578,857	53,209	54.00
60.00	06000	LABORATORY	0.125101	657,034	82,196	60.00
64.00	06400	INTRAVENOUS THERAPY	0.507858	50,702	25,749	64.00
65.00	06500	RESPIRATORY THERAPY	0.242416	257,205	62,351	65.00
65.01	03610	SLEEP LAB	0.242301	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0.944011	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.333280	121,172	40,384	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239847	98,106	23,530	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.409091	9,701	3,969	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.424863	692,688	294,298	73.00
76.97	07697	CARDIAC REHABILITATION	0.525763	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.275587	4,632	1,277	90.00
91.00	09100	EMERGENCY	0.290090	6,800	1,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.844291	1,250	1,055	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,886,600	660,798	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,886,600		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-3 | Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.201589	587	118	50.00
51.00	05100	RECOVERY ROOM	0.066404	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.108378	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091920	174,438	16,034	54.00
60.00	06000	LABORATORY	0.125101	346,066	43,293	60.00
64.00	06400	INTRAVENOUS THERAPY	0.507858	7,967	4,046	64.00
65.00	06500	RESPIRATORY THERAPY	0.242416	221,351	53,659	65.00
65.01	03610	SLEEP LAB	0.242301	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0.944011	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.333280	974,889	324,911	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239847	2,952	708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.409091	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.424863	849,540	360,938	73.00
76.97	07697	CARDIAC REHABILITATION	0.525763	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.275587	2,640	728	90.00
91.00	09100	EMERGENCY	0.290090	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.844291	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,580,430	804,435	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,580,430		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-3 | Date/Time Prepared: 8/22/2018 10:32 am

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.201589	0	0	50.00
51.00	05100	RECOVERY ROOM	0.066404	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.108378	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091920	0	0	54.00
60.00	06000	LABORATORY	0.125101	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.507858	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.242416	0	0	65.00
65.01	03610	SLEEP LAB	0.242301	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0.944011	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.333280	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239847	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.409091	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.424863	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.525763	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.275587	0	0	90.00
91.00	09100	EMERGENCY	0.290090	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.844291	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1334	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part B Date/Time Prepared: 8/22/2018 10:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	13,791,884	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	13,791,884	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	13,929,803	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	10,088,982	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,294,596	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)	3,294,596	30.00
31.00	Primary payer payments	555	31.00
32.00	Subtotal (line 30 minus line 31)	3,294,041	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)	2,037,546	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,324,405	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,222,840	36.00
37.00	Subtotal (see instructions)	4,618,446	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)	4,618,446	40.00
40.01	Sequestration adjustment (see instructions)	92,369	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,521,923	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	4,154	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: 14-1334	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part B Date/Time Prepared: 8/22/2018 10:32 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,185,306		4,134,748	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		03/29/2018	325,522	03/29/2018	387,175	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)		325,522		387,175	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,510,828		4,521,923	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		55,302		4,154	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,566,130		4,526,077	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,391,826		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	03/29/2018	61,036		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)		-61,036		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)		3,330,790		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		160,994		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,491,784		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1334	Period: From 04/01/2017 To 03/31/2018	Worksheet E-1 Part II Date/Time Prepared: 8/22/2018 10:32 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		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 - SWING BEDS | Provider CCN: 14-1334 | Component CCN: 14-Z334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E-2 | Date/Time Prepared: 8/22/2018 10:32 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,803,646	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	812,479	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	2,139	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	3,616,125	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,616,125	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	3,616,125	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	53,080	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	3,563,045	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	3,563,045	0	19.00
19.01	Sequestration adjustment (see instructions)	71,261	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	3,330,790	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	160,994	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2017 To 03/31/2018	Worksheet E-2 Date/Time Prepared: 8/22/2018 10:32 am
	Title XIX	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1334	Period: From 04/01/2017 To 03/31/2018	Worksheet E-3 Part V Date/Time Prepared: 8/22/2018 10:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,757,397	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,757,397	4.00
5.00	Primary payer payments	2,586	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,772,385	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,772,385	19.00
20.00	Deductibles (exclude professional component)	213,336	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,559,049	22.00
23.00	Coinsurance	5,593	23.00
24.00	Subtotal (line 22 minus line 23)	1,553,456	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	68,670	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	44,636	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	47,266	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,598,092	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,598,092	30.00
30.01	Sequestration adjustment (see instructions)	31,962	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,510,828	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	55,302	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G | Date/Time Prepared: 8/22/2018 10:32 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,078,579	0	10,040	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	41,343,011	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-25,459,682	0	0	0	6.00
7.00	Inventory	1,539,517	0	0	0	7.00
8.00	Prepaid expenses	79,858	0	0	0	8.00
9.00	Other current assets	91,706	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)	21,672,989	0	10,040	0	11.00
	FIXED ASSETS					
12.00	Land	171,136	0	0	0	12.00
13.00	Land improvements	1,145,551	0	0	0	13.00
14.00	Accumulated depreciation	-781,984	0	0	0	14.00
15.00	Buildings	26,641,518	0	0	0	15.00
16.00	Accumulated depreciation	-13,567,671	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	196,295	0	0	0	21.00
22.00	Accumulated depreciation	-125,200	0	0	0	22.00
23.00	Major movable equipment	17,733,708	0	0	0	23.00
24.00	Accumulated depreciation	-9,517,627	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)	21,895,726	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	538,289	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	-309,197	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	229,092	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	43,797,807	0	10,040	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,375,486	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,364,494	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	288,695	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	1,223,149	0	0	0	43.00
44.00	Other current liabilities	722,053	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,973,877	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	14,590,430	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	26,484	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,616,914	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,590,791	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	24,207,016				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			10,040		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)	24,207,016	0	10,040	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	43,797,807	0	10,040	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G-1 | Date/Time Prepared: 8/22/2018 10:32 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		21,747,171		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,613,261				2.00
3.00	Total (sum of line 1 and line 2)		26,360,432		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	GRANT TRANSACTIONS	0		0		9,040	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		26,360,432		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	TRANSFER	2,153,416		0		0	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)		2,153,416		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,207,016		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	1,000		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)	1,000		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00	GRANT TRANSACTIONS		0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	9,040		0	10.00
11.00	Subtotal (line 3 plus line 10)	10,040		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00	TRANSFER		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)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	10,040		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1334 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 8/22/2018 10:32 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,064,199		2,064,199	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,105,500		1,105,500	5.00
6.00	Swing bed - NF	165,000		165,000	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)	3,334,699		3,334,699	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,334,699		3,334,699	17.00
18.00	Ancillary services	9,338,967	171,173,237	180,512,204	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)	12,673,666	171,173,237	183,846,903	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		43,743,959		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)		43,743,959		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1334	Period: From 04/01/2017 To 03/31/2018	Worksheet G-3 Date/Time Prepared: 8/22/2018 10:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	183,846,903	1.00
2.00	Less contractual allowances and discounts on patients' accounts	114,791,901	2.00
3.00	Net patient revenues (line 1 minus line 2)	69,055,002	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	43,743,959	4.00
5.00	Net income from service to patients (line 3 minus line 4)	25,311,043	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	6,270	6.00
7.00	Income from investments	514,412	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	2,374	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	96,378	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	545	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	12,739	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	45,844	22.00
23.00	Governmental appropriations	20,965	23.00
24.00	DEPARTMENTAL PROGRAM	2,590	24.00
25.00	Total other income (sum of lines 6-24)	702,117	25.00
26.00	Total (line 5 plus line 25)	26,013,160	26.00
27.00	LOSS ON EQUIP., CORP ALLOC, CONTR	21,399,899	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	21,399,899	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,613,261	29.00