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: 15-1323	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/30/2017 1:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2017 Time: 1:22 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPT. OF LAGRANGE CTY IN (15-1323) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	226,478	-340,721	16,740	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	167,405	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	393,883	-340,721	16,740	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 12:53 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 207 NORTH TOWNLINE ROAD	PO Box:			1.00
2.00	City: LAGRANGE	State: IN	Zip Code: 46761-1325	County: LAGRANGE	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	COMMUNITY HOSPT. OF LAGRANGE CTY IN	151323	99915	1	05/01/2005	N	O	P	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	SWING BEDS	15Z323	99915		05/01/2005	N	O	N	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
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
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)	01/01/2016	12/31/2016	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2017 12:53 pm

		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	
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

		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		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2017 12:53 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2017 12:53 pm

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	70,073	4,614	27,643	118.01

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		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
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	15H032	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46845	143.00

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

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

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 12:53 pm

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40
					1.00	

Multicampus

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
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
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)	19,507	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2017 12:53 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			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.	N			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)	N		N		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)	Y	04/30/2015	Y	04/30/2015	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.	Y		Y		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: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 12:53 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	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.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC		NICKESON		41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8406		ERIC.NICKESON@PARKVIEW.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1323	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 12:53 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2017 12:53 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	66,960.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	66,960.00	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	66,960.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2017 12:53 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	762	25	1,997			1.00
2.00	HMO and other (see instructions)	566	215				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	396	0	396			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		263	263			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,158	288	2,656			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		141	466			13.00
14.00	Total (see instructions)	1,158	429	3,122	0.00	172.10	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
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	172.10	27.00
28.00	Observation Bed Days		13	847			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			18			31.00
32.00	Labor & delivery days (see instructions)	0	5	188			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2017 12:53 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	308	34	1,009	1.00
2.00	HMO and other (see instructions)			178	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	308	34	1,009	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
25.10	CMHC - CORF	0.00					25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/30/2017 12:53 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.276855	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	565,190	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	115,691	5.00
6.00	Medicaid charges	6,256,396	6.00
7.00	Medicaid cost (line 1 times line 6)	1,732,115	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)	1,051,234	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)	369,672	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	3,333,058	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	922,774	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)	553,102	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,604,336	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	623,653	809,925	1,433,578	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	172,661	224,232	396,893	21.00
22.00	Partial payment by patients approved for charity care	992	6,747	7,739	22.00
23.00	Cost of charity care (line 21 minus line 22)	171,669	217,485	389,154	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,434,778	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	212,603	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,222,175	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,168,930	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,558,084	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,162,420	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,516,310	1,516,310	-213,332	1,302,978	1.00
1.01	00101	EMS WEST STATION		0	0	16,040	16,040	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	541,673	541,673	2.00
2.01	00201	EMS WEST STATION EQUIP.		0	0	19,794	19,794	2.01
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,527,874	3,005,589	4,533,463	0	4,533,463	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,449,953	3,386,149	8,836,102	-384,340	8,451,762	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	279,101	717,686	996,787	-26,334	970,453	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,800	80,800	0	80,800	8.00
9.00	00900	HOUSEKEEPING	168,460	40,960	209,420	-25	209,395	9.00
10.00	01000	DIETARY	343,647	312,858	656,505	-428,647	227,858	10.00
11.00	01100	CAFETERIA	0	0	0	425,806	425,806	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	307,790	1,111	308,901	-98	308,803	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-44,314	-44,314	-74	-44,388	14.00
15.00	01500	PHARMACY	471,904	1,326,995	1,798,899	-1,272,215	526,684	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,602,229	479,963	2,082,192	-430,450	1,651,742	30.00
43.00	04300	NURSERY	0	0	0	173,178	173,178	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	710,824	352,951	1,063,775	-5,150	1,058,625	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	590,253	590,253	52.00
53.00	05300	ANESTHESIOLOGY	0	809,999	809,999	0	809,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	647,808	618,281	1,266,089	-81,988	1,184,101	54.00
60.00	06000	LABORATORY	0	983,496	983,496	-161	983,335	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	289,167	11,039	300,206	-3,864	296,342	65.00
66.00	06600	PHYSICAL THERAPY	555,759	12,432	568,191	-211,195	356,996	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	131,357	131,357	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	77,229	77,229	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	536,400	536,400	-203,396	333,004	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	203,359	203,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	75	75	1,272,679	1,272,754	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	126,251	104,673	230,924	1,514	232,438	90.01
91.00	09100	EMERGENCY	776,130	1,695,095	2,471,225	-5,744	2,465,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	966,294	251,432	1,217,726	-820	1,216,906	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		205,595	205,595	-205,595	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,223,191	16,405,575	30,628,766	-20,546	30,608,220	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,870	6,870	0	6,870	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,432	1,432	-560	872	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	-21,105	-21,105	21,106	1	194.00
194.01	07951	FOUNDATION	60,554	7,194	67,748	0	67,748	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	13,487	127,128	140,615	0	140,615	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		TOTAL (SUM OF LINES 118-199)	14,297,232	16,527,094	30,824,326	0	30,824,326	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	16,942	1,319,920		1.00
1.01	00101	EMS WEST STATION	0	16,040		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	541,673		2.00
2.01	00201	EMS WEST STATION EQUIP.	0	19,794		2.01
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-826,005	3,707,458		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,333,621	6,118,141		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-4,683	965,770		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,800		8.00
9.00	00900	HOUSEKEEPING	0	209,395		9.00
10.00	01000	DIETARY	0	227,858		10.00
11.00	01100	CAFETERIA	-252,963	172,843		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	308,803		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-44,388		14.00
15.00	01500	PHARMACY	0	526,684		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	19,046	1,670,788		30.00
43.00	04300	NURSERY	0	173,178		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,058,625		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	590,253		52.00
53.00	05300	ANESTHESIOLOGY	-788,419	21,580		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,740	1,182,361		54.00
60.00	06000	LABORATORY	0	983,335		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	296,342		65.00
66.00	06600	PHYSICAL THERAPY	0	356,996		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	131,357		67.00
68.00	06800	SPEECH PATHOLOGY	-13,038	64,191		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	333,004		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	203,359		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-395,853	876,901		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	232,438		90.01
91.00	09100	EMERGENCY	-660,585	1,804,896		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	1,216,906		95.00
99.10	09910	CORF	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,240,919	25,367,301		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,870		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	872		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	1		194.00
194.01	07951	FOUNDATION	0	67,748		194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	140,615		194.03
194.04	07954	ER PHYSICIAN	0	0		194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0		194.06
200.00		TOTAL (SUM OF LINES 118-199)	-5,240,919	25,583,407		200.00

RECLASSIFICATIONS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 12:53 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - REHAB THERAPY RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	128,481	2,876	1.00
2.00	SPEECH PATHOLOGY	68.00	75,538	1,691	2.00
	0		204,019	4,567	
	B - OB RECLASS				
1.00	NURSERY	43.00	143,674	29,504	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	489,693	100,560	2.00
	0		633,367	130,064	
	C - CLINIC DIETICIAN				
1.00	LIFEBRIDGE SENIOR CARE	90.01	2,159	0	1.00
	TOTALS		2,159	0	
	F - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	222,218	203,588	1.00
	0		222,218	203,588	
	G - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,736	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,997	2.00
	0		0	47,733	
	H - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,273,319	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
	0		0	1,273,319	
	I - SALARY RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,699,527	1.00
	0		0	2,699,527	
	J - OCCUPATIONAL HEALTH RECLASS				
1.00	OCCUPATIONAL HEALTH	194.00	0	21,106	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
	0		0	21,106	
	K - DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	499,801	1.00
2.00	EMS WEST STATION	1.01	0	16,040	2.00
3.00	EMS WEST STATION EQUIP.	2.01	0	18,974	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	6,892	4.00
	0		0	541,707	
	L - BLDG & LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	88,044	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	28,875	2.00
3.00	EMS WEST STATION EQUIP.	2.01	0	820	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	0		0	117,739	
	M - INTEREST RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	205,595	1.00
	0		0	205,595	
	N - IMPLANTABLE MEDICAL SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	203,359	1.00
	0		0	203,359	
	O - RECLASS HOSPITALIST FEES				
1.00	ADULTS & PEDIATRICS	30.00	0	336,000	1.00
	0		0	336,000	
500.00	Grand Total: Increases		1,061,763	5,784,304	500.00

RECLASSIFICATIONS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 12:53 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - REHAB THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	204,019	4,567	0		1.00
2.00		0.00	0	0	0		2.00
	0		204,019	4,567			
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	633,367	130,064	0		1.00
2.00		0.00	0	0	0		2.00
	0		633,367	130,064			
	C - CLINIC DIETICIAN						
1.00	DIETARY	10.00	2,159	0	0		1.00
	TOTALS		2,159	0			
	F - CAFETERIA RECLASS						
1.00	DIETARY	10.00	222,218	203,588	0		1.00
	0		222,218	203,588			
	G - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	47,733	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	47,733			
	H - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	1,268,050	0		1.00
2.00	OPERATING ROOM	50.00	0	1,442	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,804	0		3.00
4.00	EMERGENCY	91.00	0	23	0		4.00
	0		0	1,273,319			
	I - SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	2,699,527	0	0		1.00
	0		2,699,527	0			
	J - OCCUPATIONAL HEALTH RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,340	0		1.00
2.00	LABORATORY	60.00	0	161	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	96	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	875	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	37	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	640	0		6.00
7.00	EMERGENCY	91.00	0	3,957	0		7.00
	0		0	21,106			
	K - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	541,707	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	0		4.00
	0		0	541,707			
	L - BLDG & LEASE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	25,200	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,844	10		2.00
3.00	AMBULANCE SERVICES	95.00	0	820	10		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	7,499	0		4.00
5.00	OPERATION OF PLANT	7.00	0	1,134	0		5.00
6.00	HOUSEKEEPING	9.00	0	25	0		6.00
7.00	DIETARY	10.00	0	682	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	74	0		8.00
9.00	PHARMACY	15.00	0	4,165	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	3,019	0		10.00
11.00	OPERATING ROOM	50.00	0	3,708	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	3,768	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,734	0		13.00
14.00	EMERGENCY	91.00	0	1,764	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	560	0		15.00
16.00	LIFEBRIDGE SENIOR CARE	90.01	0	645	0		16.00
17.00	NURSING ADMINISTRATION	13.00	0	98	0		17.00
	0		0	117,739			
	M - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	205,595	11		1.00
	0		0	205,595			
	N - IMPLANTABLE MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	203,359	0		1.00
	0		0	203,359			
	O - RECLASS HOSPITALIST FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	336,000	0		1.00
	0		0	336,000			
500.00	Grand Total: Decreases		3,761,290	3,084,777			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2017 12:53 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	282,529	0	0	0	0	1.00
2.00	Land Improvements	1,972,720	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,429,858	0	0	0	0	3.00
4.00	Building Improvements	29,098	0	0	0	0	4.00
5.00	Fixed Equipment	7,798,716	770,217	0	770,217	5,888	5.00
6.00	Movable Equipment	7,483,570	1,076,759	0	1,076,759	620,075	6.00
7.00	HIT designated Assets	1,578,837	19,507	0	19,507	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,575,328	1,866,483	0	1,866,483	625,963	8.00
9.00	Reconciling Items	34,780	764,948	0	764,948	0	9.00
10.00	Total (line 8 minus line 9)	32,540,548	1,101,535	0	1,101,535	625,963	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	282,529	0	1.00
2.00	Land Improvements	1,972,720	452,240	2.00
3.00	Buildings and Fixtures	13,429,858	46,946	3.00
4.00	Building Improvements	29,098	13,778	4.00
5.00	Fixed Equipment	8,563,045	508,867	5.00
6.00	Movable Equipment	7,940,254	3,776,236	6.00
7.00	HIT designated Assets	1,598,344	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,815,848	4,798,067	8.00
9.00	Reconciling Items	799,728	0	9.00
10.00	Total (line 8 minus line 9)	33,016,120	4,798,067	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 5/30/2017 12:53 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,516,310	0	0	0	0	1.00
1.01	EMS WEST STATION	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	1,516,310	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	1,516,310	1.00
1.01	EMS WEST STATION	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
2.01	EMS WEST STATION EQUIP.	0	0	2.01
3.00	Total (sum of lines 1-2)	0	1,516,310	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2017 12:53 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,956,443	0	23,956,443	0.747349	0	1.00
1.01	EMS WEST STATION	320,808	0	320,808	0.010008	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	7,707,816	162,280	7,545,536	0.235392	0	2.00
2.01	EMS WEST STATION EQUIP.	232,438	0	232,438	0.007251	0	2.01
3.00	Total (sum of lines 1-2)	32,217,505	162,280	32,055,225	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	991,545	88,044	1.00
1.01	EMS WEST STATION	0	0	0	16,040	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	499,801	28,875	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	18,974	820	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,526,360	117,739	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	205,595	34,736	0	0	1,319,920	1.00
1.01	EMS WEST STATION	0	0	0	0	16,040	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,997	0	0	541,673	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	0	19,794	2.01
3.00	Total (sum of lines 1-2)	205,595	47,733	0	0	1,897,427	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/30/2017 12:53 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-998	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
1.01	Investment income - EMS WEST STATION (chapter 2)		0	EMS WEST STATION	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - EMS WEST STATION EQUIP. (chapter 2)		0	EMS WEST STATION EQUIP.	2.01	0	2.01
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)	A	-4,550	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,693,174			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	A	-133	OPERATION OF PLANT	7.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,204,455			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-252,963	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - EMS WEST STATION		0	EMS WEST STATION	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - EMS WEST STATION EQUIP.		0	EMS WEST STATION EQUIP.	2.01	0	27.01
28.00	Non-physician Anesthetist		0	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	OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/30/2017 12:53 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HAF NET FEE EXPENSE	A	53,362	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	CAH HIT ADJ DEPR CARRYFRWD 2016	A	-3,374	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	CAH HIT ADJ DEPR CARRYFRWD 2015	A	-18,320	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CAH HIT ADJ DEPR CARRYFRWD 2014	A	-24,262	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	CAH HIT ADJ DEPR CARRYFRWD 2013	A	-57,396	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CAH HIT ADJ DEPR CARRYFRWD 2012	A	-82,235	ADMINISTRATIVE & GENERAL	5.00	0	33.05
34.00	MISCELLANEOUS REVENUE	B	2,085	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	SPEECH THERAPY CONTRACTED	B	-13,038	SPEECH PATHOLOGY	68.00	0	35.00
38.00	PHARMACY EMPLOYEE RX PURCHASES	B	-395,853	DRUGS CHARGED TO PATIENTS	73.00	0	38.00
40.00	SELF INSURANCE	A	-826,005	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	LOBBY % OF DUES & SUBSCRIPTIONS	A	-3,151	ADMINISTRATIVE & GENERAL	5.00	0	41.00
44.00	EKG INTERPRETATION COSTS	A	-1,740	RADIOLOGY-DIAGNOSTIC	54.00	0	44.00
47.00	ADD-BACK OF DEMOLISHED ASSET DEPREC	A	17,940	CAP REL COSTS-BLDG & FIXT	1.00	9	47.00
48.00	ADD-BACK OF DEMOLITION COSTS	A	4,125	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00			0		0.00	0	49.00
49.01	TELEMETRY MONITORING EXPENSE	A	19,268	ADULTS & PEDIATRICS	30.00	0	49.01
49.02	MEDICAL DIRECTOR ADDITIONAL A/P	A	-222	ADULTS & PEDIATRICS	30.00	0	49.02
49.03	ON-CALL PROF TIME	A	-82,612	ANESTHESIOLOGY	53.00	0	49.03
49.04	GROSS-UP ANESTHESIA EXPENSE FOR A/R	A	326,782	ANESTHESIOLOGY	53.00	0	49.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,240,919				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: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2017 12:53 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,721,740	4,820,000	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY ADJ.	0	2,106,195	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,721,740	6,926,195	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		0.00	PARKVIEW HEALTH SYSTEM, INC.	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	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: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2017 12:53 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-98,260	0		1.00
2.00	-2,106,195	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-2,204,455			5.00

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

	Related Organization(s) and/or Home Office		
	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	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			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: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2017 12:53 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	AGGREGATE-ANESTHESIOLOGY	406,725	330,464	76,261	0	0	1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	702,125	702,125	0	0	0	2.00
3.00	91.00	DR. A	30,000	0	30,000	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	1,523,276	660,585	862,691	0	0	4.00
5.00	30.00	DR. B	13,390	0	13,390	0	0	5.00
6.00	90.01	LIFEBRIDGE SENIOR CARE	14,864	0	14,864	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,690,380	1,693,174	997,206		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	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	91.00	DR. A	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	DR. B	0	0	0	0	0	5.00
6.00	90.01	LIFEBRIDGE SENIOR CARE	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	330,464		1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	702,125		2.00
3.00	91.00	DR. A	0	0	0	0		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	660,585		4.00
5.00	30.00	DR. B	0	0	0	0		5.00
6.00	90.01	LIFEBRIDGE SENIOR CARE	0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,693,174		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,319,920	1,319,920				1.00
1.01	00101	EMS WEST STATION	16,040	0	16,040			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	541,673			541,673		2.00
2.01	00201	EMS WEST STATION EQUIP.	19,794			0	19,794	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,707,458	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,118,141	238,550	0	97,897	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	965,770	74,970	0	30,767	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	80,800	4,286	0	1,759	0	8.00
9.00	00900	HOUSEKEEPING	209,395	14,028	0	5,757	0	9.00
10.00	01000	DIETARY	227,858	56,283	0	23,098	0	10.00
11.00	01100	CAFETERIA	172,843	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	308,803	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-44,388	26,735	0	10,972	0	14.00
15.00	01500	PHARMACY	526,684	23,008	0	9,442	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,541	0	1,863	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,670,788	297,070	0	121,913	0	30.00
43.00	04300	NURSERY	173,178	4,473	0	1,836	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,058,625	169,323	0	69,487	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	590,253	21,144	0	8,677	0	52.00
53.00	05300	ANESTHESIOLOGY	21,580	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,182,361	85,492	0	35,084	0	54.00
60.00	06000	LABORATORY	983,335	33,478	0	13,739	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	296,342	17,519	0	7,189	0	65.00
66.00	06600	PHYSICAL THERAPY	356,996	56,113	0	23,028	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,357	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	64,191	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	333,004	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	203,359	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	876,901	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	232,438	15,418	0	6,327	0	90.01
91.00	09100	EMERGENCY	1,804,896	117,259	0	48,121	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,216,906	0	16,040	0	19,794	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,367,301	1,259,690	16,040	516,956	19,794	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,870	3,778	0	1,550	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	872	56,452	0	23,167	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	1	0	0	0	0	194.00
194.01	07951	FOUNDATION	67,748	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	140,615	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 12:53 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
		0	1.00	1.01	2.00	2.01	
202.00	TOTAL (sum lines 118-201)	25,583,407	1,319,920	16,040	541,673	19,794	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			4.00	4A	5.00	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,707,458					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,012,636	7,467,224	7,467,224			5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	102,758	1,174,265	483,836	0	1,658,101	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	86,845	35,783	0	7,062	8.00
9.00	00900	HOUSEKEEPING	62,023	291,203	119,985	0	23,113	9.00
10.00	01000	DIETARY	43,912	351,151	144,686	0	92,729	10.00
11.00	01100	CAFETERIA	81,815	254,658	104,927	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	113,321	422,124	173,929	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-6,681	0	0	44,048	14.00
15.00	01500	PHARMACY	173,743	732,877	301,970	0	37,907	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,404	2,639	0	7,481	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	356,711	2,446,482	1,008,037	0	489,440	30.00
43.00	04300	NURSERY	52,897	232,384	95,750	0	7,369	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	261,708	1,559,143	642,418	0	278,969	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	180,293	800,367	329,778	0	34,836	52.00
53.00	05300	ANESTHESIOLOGY	0	21,580	8,892	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	238,507	1,541,444	635,126	0	140,852	54.00
60.00	06000	LABORATORY	0	1,030,552	424,621	0	55,157	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	106,464	427,514	176,150	0	28,863	65.00
66.00	06600	PHYSICAL THERAPY	129,502	565,639	233,062	0	92,450	66.00
67.00	06700	OCCUPATIONAL THERAPY	47,303	178,660	73,614	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	27,811	92,002	37,908	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	333,004	137,209	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	203,359	83,791	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	876,901	361,312	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	47,277	301,460	124,211	0	25,401	90.01
91.00	09100	EMERGENCY	285,752	2,256,028	929,558	0	193,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	355,765	1,608,505	662,757	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,680,198	25,255,094	7,331,949	0	1,558,868	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,198	5,026	0	6,225	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	80,491	33,165	0	93,008	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	1	0	0	0	194.00
194.01	07951	FOUNDATION	22,294	90,042	37,100	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	4,966	145,581	59,984	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,707,458	25,583,407	7,467,224	0	1,658,101	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
			8.00	9.00	10.00	11.00	12.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	129,690					8.00
9.00	00900	HOUSEKEEPING	0	434,301				9.00
10.00	01000	DIETARY	921	24,738	614,225			10.00
11.00	01100	CAFETERIA	0	0	0	359,585		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	19,485	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,751	0	0	0	14.00
15.00	01500	PHARMACY	0	10,113	0	21,290	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,996	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,377	130,572	614,225	69,815	0	30.00
43.00	04300	NURSERY	2,270	1,966	0	7,958	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,129	74,424	0	45,246	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,704	9,294	0	27,073	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,481	37,577	0	45,328	0	54.00
60.00	06000	LABORATORY	0	14,715	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,660	7,700	0	22,602	0	65.00
66.00	06600	PHYSICAL THERAPY	6,381	24,664	0	26,499	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,114	0	0	5,661	0	67.00
68.00	06800	SPEECH PATHOLOGY	246	0	0	3,323	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	6,777	0	10,583	0	90.01
91.00	09100	EMERGENCY	24,797	51,540	0	49,635	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,147	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	126,227	407,827	614,225	354,498	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,661	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,463	24,813	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	3,815	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	1,272	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	129,690	434,301	614,225	359,585	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	615,538					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	49,118				14.00
15.00	01500	PHARMACY	0	2,386	1,106,543			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	18,520		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	215,148	766	91	2,030	0	30.00
43.00	04300	NURSERY	24,493	976	33	400	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	139,486	8,615	353	304	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83,481	3,325	113	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,329	1,657	5,923	0	54.00
60.00	06000	LABORATORY	0	0	1,815	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	218	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	159	119	1,404	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	53	40	259	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6	5	94	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,115	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,229	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,090,464	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	36	0	0	0	90.01
91.00	09100	EMERGENCY	152,930	3,519	1,667	8,106	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,292	10,186	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	615,538	49,024	1,106,543	18,520	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	53	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	11	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	615,538	49,118	1,106,543	18,520	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	
			19.00	20.00	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
20.00	02000	NURSING SCHOOL		0				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	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
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	EMS WEST STATION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	EMS WEST STATION EQUIP.					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
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
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,012,983	0	5,012,983		30.00
43.00	04300	NURSERY	373,599	0	373,599		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,768,087	0	2,768,087		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,295,971	0	1,295,971		52.00
53.00	05300	ANESTHESIOLOGY	30,472	0	30,472		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,427,717	0	2,427,717		54.00
60.00	06000	LABORATORY	1,526,860	0	1,526,860		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	664,707	0	664,707		65.00
66.00	06600	PHYSICAL THERAPY	950,377	0	950,377		66.00
67.00	06700	OCCUPATIONAL THERAPY	260,401	0	260,401		67.00
68.00	06800	SPEECH PATHOLOGY	133,584	0	133,584		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	485,328	0	485,328		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	296,379	0	296,379		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,328,677	0	2,328,677		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	468,468	0	468,468		90.01
91.00	09100	EMERGENCY	3,670,971	0	3,670,971		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,290,887	0	2,290,887		95.00
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,985,468	0	24,985,468		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,127	0	25,127		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	234,953	0	234,953		192.00
194.00	07950	OCCUPATIONAL HEALTH	1	0	1		194.00
194.01	07951	FOUNDATION	131,010	0	131,010		194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	206,848	0	206,848		194.03
194.04	07954	ER PHYSICIAN	0	0	0		194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0		194.06
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	25,583,407	0	25,583,407		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	238,550	0	97,897	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	74,970	0	30,767	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,286	0	1,759	0	8.00
9.00	00900	HOUSEKEEPING	0	14,028	0	5,757	0	9.00
10.00	01000	DIETARY	0	56,283	0	23,098	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,735	0	10,972	0	14.00
15.00	01500	PHARMACY	0	23,008	0	9,442	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,541	0	1,863	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	297,070	0	121,913	0	30.00
43.00	04300	NURSERY	0	4,473	0	1,836	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	169,323	0	69,487	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,144	0	8,677	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	85,492	0	35,084	0	54.00
60.00	06000	LABORATORY	0	33,478	0	13,739	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	17,519	0	7,189	0	65.00
66.00	06600	PHYSICAL THERAPY	0	56,113	0	23,028	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	15,418	0	6,327	0	90.01
91.00	09100	EMERGENCY	0	117,259	0	48,121	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	16,040	0	19,794	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,259,690	16,040	516,956	19,794	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,778	0	1,550	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	56,452	0	23,167	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,319,920	16,040	541,673	19,794	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			2A	4.00	5.00	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	336,447	0	336,447			5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	105,737	0	21,800	0	127,537	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,045	0	1,612	0	543	8.00
9.00	00900	HOUSEKEEPING	19,785	0	5,406	0	1,778	9.00
10.00	01000	DIETARY	79,381	0	6,519	0	7,133	10.00
11.00	01100	CAFETERIA	0	0	4,728	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,837	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,707	0	0	0	3,388	14.00
15.00	01500	PHARMACY	32,450	0	13,606	0	2,916	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,404	0	119	0	575	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	418,983	0	45,415	0	37,644	30.00
43.00	04300	NURSERY	6,309	0	4,314	0	567	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	238,810	0	28,945	0	21,458	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,821	0	14,859	0	2,680	52.00
53.00	05300	ANESTHESIOLOGY	0	0	401	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,576	0	28,617	0	10,834	54.00
60.00	06000	LABORATORY	47,217	0	19,132	0	4,243	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	24,708	0	7,937	0	2,220	65.00
66.00	06600	PHYSICAL THERAPY	79,141	0	10,501	0	7,111	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,317	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,708	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,182	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,775	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	16,280	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	21,745	0	5,597	0	1,954	90.01
91.00	09100	EMERGENCY	165,380	0	41,883	0	14,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	35,834	0	29,862	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,812,480	0	330,352	0	119,904	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,328	0	226	0	479	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,619	0	1,494	0	7,154	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	1,672	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	2,703	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,897,427	0	336,447	0	127,537	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
			8.00	9.00	10.00	11.00	12.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,200					8.00
9.00	00900	HOUSEKEEPING	0	26,969				9.00
10.00	01000	DIETARY	58	1,536	94,627			10.00
11.00	01100	CAFETERIA	0	0	0	4,728		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	256	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	730	0	0	0	14.00
15.00	01500	PHARMACY	0	628	0	280	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	124	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,298	8,108	94,627	918	0	30.00
43.00	04300	NURSERY	144	122	0	105	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,210	4,622	0	595	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	487	577	0	356	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,169	2,333	0	596	0	54.00
60.00	06000	LABORATORY	0	914	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	105	478	0	297	0	65.00
66.00	06600	PHYSICAL THERAPY	403	1,532	0	348	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	134	0	0	74	0	67.00
68.00	06800	SPEECH PATHOLOGY	16	0	0	44	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	421	0	139	0	90.01
91.00	09100	EMERGENCY	1,568	3,200	0	653	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	389	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,981	25,325	94,627	4,661	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	103	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	219	1,541	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	50	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	17	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,200	26,969	94,627	4,728	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	8,093					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,970				14.00
15.00	01500	PHARMACY	0	1,067	50,947			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	7,222		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,828	343	4	792	0	30.00
43.00	04300	NURSERY	322	436	2	156	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,834	3,853	16	118	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,098	1,487	5	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	594	76	2,310	0	54.00
60.00	06000	LABORATORY	0	0	84	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	97	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	71	5	547	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	24	2	101	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3	0	37	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,762	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,128	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	50,207	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	16	0	0	0	90.01
91.00	09100	EMERGENCY	2,011	1,574	77	3,161	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,472	469	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,093	21,927	50,947	7,222	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	24	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	5	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	19,855	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,093	41,825	50,947	7,222	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	
			19.00	20.00	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
20.00	02000	NURSING SCHOOL		0				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS						30.00
43.00	04300	NURSERY						43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM						50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM						52.00
53.00	05300	ANESTHESIOLOGY						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC						54.00
60.00	06000	LABORATORY						60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65.00	06500	RESPIRATORY THERAPY						65.00
66.00	06600	PHYSICAL THERAPY						66.00
67.00	06700	OCCUPATIONAL THERAPY						67.00
68.00	06800	SPEECH PATHOLOGY						68.00
69.00	06900	ELECTROCARDIOLOGY						69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS						73.00
76.97	07697	CARDIAC REHABILITATION						76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY						76.98
76.99	07699	LITHOTRIPSY						76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC						90.00
90.01	09001	LIFEBRIDGE SENIOR CARE						90.01
91.00	09100	EMERGENCY						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
99.10	09910	CORF						99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY						99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
194.00	07950	OCCUPATIONAL HEALTH						194.00
194.01	07951	FOUNDATION						194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS						194.03
194.04	07954	ER PHYSICIAN						194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB						194.06
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	EMS WEST STATION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	EMS WEST STATION EQUIP.					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
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
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	611,960	0	611,960		30.00
43.00	04300	NURSERY	12,477	0	12,477		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	301,461	0	301,461		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,370	0	51,370		52.00
53.00	05300	ANESTHESIOLOGY	401	0	401		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,105	0	167,105		54.00
60.00	06000	LABORATORY	71,590	0	71,590		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	35,842	0	35,842		65.00
66.00	06600	PHYSICAL THERAPY	99,659	0	99,659		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,652	0	3,652		67.00
68.00	06800	SPEECH PATHOLOGY	1,808	0	1,808		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,944	0	12,944		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,903	0	7,903		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,487	0	66,487		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	29,872	0	29,872		90.01
91.00	09100	EMERGENCY	234,367	0	234,367		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	68,026	0	68,026		95.00
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,776,924	0	1,776,924		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,144	0	6,144		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	90,033	0	90,033		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0		194.00
194.01	07951	FOUNDATION	1,746	0	1,746		194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	2,725	0	2,725		194.03
194.04	07954	ER PHYSICIAN	0	0	0		194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0		194.06
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	19,855	0	19,855		201.00
202.00		TOTAL (sum lines 118-201)	1,897,427	0	1,897,427		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	EMS WEST STATION (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMS WEST STATION EQUIP. (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	77,906					1.00
1.01	00101	EMS WEST STATION	0	9,760				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			77,906			2.00
2.01	00201	EMS WEST STATION EQUIP.			0	9,760		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	10,069,831	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,080	0	14,080	0	2,750,426	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,425	0	4,425	0	279,101	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	253	0	253	0	0	8.00
9.00	00900	HOUSEKEEPING	828	0	828	0	168,460	9.00
10.00	01000	DIETARY	3,322	0	3,322	0	119,270	10.00
11.00	01100	CAFETERIA	0	0	0	0	222,218	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	307,790	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,578	0	1,578	0	0	14.00
15.00	01500	PHARMACY	1,358	0	1,358	0	471,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268	0	268	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,534	0	17,534	0	968,862	30.00
43.00	04300	NURSERY	264	0	264	0	143,674	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,994	0	9,994	0	710,824	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,248	0	1,248	0	489,693	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,046	0	5,046	0	647,808	54.00
60.00	06000	LABORATORY	1,976	0	1,976	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,034	0	1,034	0	289,167	65.00
66.00	06600	PHYSICAL THERAPY	3,312	0	3,312	0	351,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	128,481	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	75,538	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	910	0	910	0	128,410	90.01
91.00	09100	EMERGENCY	6,921	0	6,921	0	776,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	9,760	0	9,760	966,294	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,351	9,760	74,351	9,760	9,995,790	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	223	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,332	0	3,332	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	60,554	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	13,487	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	EMS WEST STATION (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMS WEST STATION EQUIP. (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,319,920	16,040	541,673	19,794	3,707,458	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.942469	1.643443	6.952905	2.028074	0.368175	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5A	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,467,224	18,122,864				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0			6.00
7.00	00700	OPERATION OF PLANT	0	1,174,265	0	59,401		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	86,845	0	253	10,000	8.00
9.00	00900	HOUSEKEEPING	0	291,203	0	828	0	9.00
10.00	01000	DIETARY	0	351,151	0	3,322	71	10.00
11.00	01100	CAFETERIA	0	254,658	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	422,124	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,681	0	0	1,578	0	14.00
15.00	01500	PHARMACY	0	732,877	0	1,358	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,404	0	268	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,446,482	0	17,534	2,805	30.00
43.00	04300	NURSERY	0	232,384	0	264	175	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,559,143	0	9,994	1,475	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	800,367	0	1,248	594	52.00
53.00	05300	ANESTHESIOLOGY	0	21,580	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,541,444	0	5,046	1,425	54.00
60.00	06000	LABORATORY	0	1,030,552	0	1,976	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	427,514	0	1,034	128	65.00
66.00	06600	PHYSICAL THERAPY	0	565,639	0	3,312	492	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	178,660	0	0	163	67.00
68.00	06800	SPEECH PATHOLOGY	0	92,002	0	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	333,004	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	203,359	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	876,901	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	301,460	0	910	0	90.01
91.00	09100	EMERGENCY	0	2,256,028	0	6,921	1,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,608,505	0	0	474	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,460,543	17,794,551	0	55,846	9,733	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,198	0	223	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	80,491	0	3,332	267	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	1	0	0	0	194.00
194.01	07951	FOUNDATION	0	90,042	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	145,581	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
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)		7,467,224	0	1,658,101	129,690	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.412033	0.000000	27.913688	12.969000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5A	5.00	6.00	7.00	8.00	
204.00		Cost to be allocated (per Wkst. B, Part II)		336,447	0	127,537	8,200	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.018565	0.000000	2.147051	0.820000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			9.00	10.00	11.00	12.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	58,320					9.00
10.00	01000	DIETARY	3,322	19,171				10.00
11.00	01100	CAFETERIA	0	0	8,766			11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	475	0	101,554	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,578	0	0	0	0	14.00
15.00	01500	PHARMACY	1,358	0	519	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,534	19,171	1,702	0	35,496	30.00
43.00	04300	NURSERY	264	0	194	0	4,041	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,994	0	1,103	0	23,013	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,248	0	660	0	13,773	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,046	0	1,105	0	0	54.00
60.00	06000	LABORATORY	1,976	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,034	0	551	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,312	0	646	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	138	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	81	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	910	0	258	0	0	90.01
91.00	09100	EMERGENCY	6,921	0	1,210	0	25,231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,765	19,171	8,642	0	101,554	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,332	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	93	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	31	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
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)	434,301	614,225	359,585	0	615,538	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			9.00	10.00	11.00	12.00	13.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	7.446862	32.039278	41.020420	0.000000	6.061189	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,969	94,627	4,728	0	8,093	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.462431	4.935945	0.539357	0.000000	0.079692	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,082,319					14.00
15.00	01500	PHARMACY	52,580	438,872				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	10,000			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,882	36	1,096	0	0	30.00
43.00	04300	NURSERY	21,498	13	216	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	189,833	140	164	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,271	45	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,287	657	3,198	0	0	54.00
60.00	06000	LABORATORY	0	720	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,793	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,513	47	758	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,164	16	140	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	134	2	51	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	333,089	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	203,359	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	432,495	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	783	0	0	0	0	90.01
91.00	09100	EMERGENCY	77,534	661	4,377	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	72,532	4,040	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,080,252	438,872	10,000	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	375	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	278	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	1,175	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	239	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
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)	49,118	1,106,543	18,520	0	0	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	0.045382	2.521334	1.852000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,825	50,947	7,222	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.020299	0.116086	0.722200	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			20.00	21.00	22.00	23.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL	0					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0		30.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
99.10	09910	CORF	0	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0		99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	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
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0		194.03
194.04	07954	ER PHYSICIAN	0	0	0	0		194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0		194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			20.00	21.00	22.00	23.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,012,983		5,012,983	0	0	30.00
43.00	04300	NURSERY	373,599		373,599	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,768,087		2,768,087	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,295,971		1,295,971	0	0	52.00
53.00	05300	ANESTHESIOLOGY	30,472		30,472	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,427,717		2,427,717	0	0	54.00
60.00	06000	LABORATORY	1,526,860		1,526,860	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	664,707	0	664,707	0	0	65.00
66.00	06600	PHYSICAL THERAPY	950,377	0	950,377	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,401	0	260,401	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	133,584	0	133,584	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	485,328		485,328	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	296,379		296,379	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,328,677		2,328,677	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	468,468		468,468	0	0	90.01
91.00	09100	EMERGENCY	3,670,971		3,670,971	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,302,017		1,302,017		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,290,887		2,290,887	0	0	95.00
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,287,485	0	26,287,485	0	0	200.00
201.00		Less Observation Beds	1,302,017		1,302,017		0	201.00
202.00		Total (see instructions)	24,985,468	0	24,985,468	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 12:53 pm

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	6,260,574		6,260,574			30.00
43.00	04300	NURSERY	557,111		557,111			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,227,696	12,234,462	15,462,158	0.179023	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	475,034	1,423,262	1,898,296	0.682702	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	341,116	1,496,259	1,837,375	0.016585	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,311,531	21,396,690	22,708,221	0.106909	0.000000	54.00
60.00	06000	LABORATORY	1,283,268	6,312,926	7,596,194	0.201003	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	531,862	1,854,581	2,386,443	0.278535	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	247,498	1,363,155	1,610,653	0.590057	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	283,694	305,714	589,408	0.441801	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	38,590	82,889	121,479	1.099647	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	461,187	1,548,347	2,009,534	0.241513	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	510,895	463,523	974,418	0.304160	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,317,785	5,686,570	8,004,355	0.290926	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	647,746	647,746	0.723228	0.000000	90.01
91.00	09100	EMERGENCY	451,472	12,006,870	12,458,342	0.294660	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,127,365	1,127,365	1.154921	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,997,757	3,997,757	0.573043	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,299,313	71,948,116	90,247,429			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,299,313	71,948,116	90,247,429			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
		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: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,012,983		5,012,983	0	5,012,983	30.00
43.00	04300	NURSERY	373,599		373,599	0	373,599	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,768,087		2,768,087	0	2,768,087	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,295,971		1,295,971	0	1,295,971	52.00
53.00	05300	ANESTHESIOLOGY	30,472		30,472	0	30,472	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,427,717		2,427,717	0	2,427,717	54.00
60.00	06000	LABORATORY	1,526,860		1,526,860	0	1,526,860	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	664,707	0	664,707	0	664,707	65.00
66.00	06600	PHYSICAL THERAPY	950,377	0	950,377	0	950,377	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,401	0	260,401	0	260,401	67.00
68.00	06800	SPEECH PATHOLOGY	133,584	0	133,584	0	133,584	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	485,328		485,328	0	485,328	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	296,379		296,379	0	296,379	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,328,677		2,328,677	0	2,328,677	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	468,468		468,468	0	468,468	90.01
91.00	09100	EMERGENCY	3,670,971		3,670,971	0	3,670,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,302,017		1,302,017		1,302,017	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,290,887		2,290,887	0	2,290,887	95.00
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,287,485	0	26,287,485	0	26,287,485	200.00
201.00		Less Observation Beds	1,302,017		1,302,017		1,302,017	201.00
202.00		Total (see instructions)	24,985,468	0	24,985,468	0	24,985,468	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,260,574		6,260,574			30.00
43.00	04300	NURSERY	557,111		557,111			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,227,696	12,234,462	15,462,158	0.179023	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	475,034	1,423,262	1,898,296	0.682702	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	341,116	1,496,259	1,837,375	0.016585	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,311,531	21,396,690	22,708,221	0.106909	0.000000	54.00
60.00	06000	LABORATORY	1,283,268	6,312,926	7,596,194	0.201003	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	531,862	1,854,581	2,386,443	0.278535	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	247,498	1,363,155	1,610,653	0.590057	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	283,694	305,714	589,408	0.441801	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	38,590	82,889	121,479	1.099647	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	461,187	1,548,347	2,009,534	0.241513	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	510,895	463,523	974,418	0.304160	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,317,785	5,686,570	8,004,355	0.290926	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	647,746	647,746	0.723228	0.000000	90.01
91.00	09100	EMERGENCY	451,472	12,006,870	12,458,342	0.294660	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,127,365	1,127,365	1.154921	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,997,757	3,997,757	0.573043	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,299,313	71,948,116	90,247,429			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,299,313	71,948,116	90,247,429			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.179023		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682702		52.00
53.00	05300	ANESTHESIOLOGY	0.016585		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106909		54.00
60.00	06000	LABORATORY	0.201003		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.278535		65.00
66.00	06600	PHYSICAL THERAPY	0.590057		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.441801		67.00
68.00	06800	SPEECH PATHOLOGY	1.099647		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241513		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.304160		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290926		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.723228		90.01
91.00	09100	EMERGENCY	0.294660		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.154921		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.573043		95.00
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
		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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,768,087	301,461	2,466,626	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,295,971	51,370	1,244,601	0	0	52.00
53.00	05300	ANESTHESIOLOGY	30,472	401	30,071	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,427,717	167,105	2,260,612	0	0	54.00
60.00	06000	LABORATORY	1,526,860	71,590	1,455,270	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	664,707	35,842	628,865	0	0	65.00
66.00	06600	PHYSICAL THERAPY	950,377	99,659	850,718	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,401	3,652	256,749	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	133,584	1,808	131,776	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	485,328	12,944	472,384	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	296,379	7,903	288,476	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,328,677	66,487	2,262,190	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	468,468	29,872	438,596	0	0	90.01
91.00	09100	EMERGENCY	3,670,971	234,367	3,436,604	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,302,017	158,944	1,143,073	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,290,887	68,026	2,222,861	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	20,900,903	1,311,431	19,589,472	0	0	200.00
201.00		Less Observation Beds	1,302,017	158,944	1,143,073	0	0	201.00
202.00		Total (line 200 minus line 201)	19,598,886	1,152,487	18,446,399	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,768,087	15,462,158	0.179023		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,295,971	1,898,296	0.682702		52.00
53.00	05300	ANESTHESIOLOGY	30,472	1,837,375	0.016585		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,427,717	22,708,221	0.106909		54.00
60.00	06000	LABORATORY	1,526,860	7,596,194	0.201003		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	664,707	2,386,443	0.278535		65.00
66.00	06600	PHYSICAL THERAPY	950,377	1,610,653	0.590057		66.00
67.00	06700	OCCUPATIONAL THERAPY	260,401	589,408	0.441801		67.00
68.00	06800	SPEECH PATHOLOGY	133,584	121,479	1.099647		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	485,328	2,009,534	0.241513		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	296,379	974,418	0.304160		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,328,677	8,004,355	0.290926		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	468,468	647,746	0.723228		90.01
91.00	09100	EMERGENCY	3,670,971	12,458,342	0.294660		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,302,017	1,127,365	1.154921		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,290,887	3,997,757	0.573043		95.00
99.10	09910	CORF	0	0	0.000000		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0.000000		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000		99.40
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	20,900,903	83,429,744			200.00
201.00		Less Observation Beds	1,302,017	0			201.00
202.00		Total (line 200 minus line 201)	19,598,886	83,429,744			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	301,461	15,462,158	0.019497	403,609	7,869	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,370	1,898,296	0.027061	0	0	52.00
53.00	05300	ANESTHESIOLOGY	401	1,837,375	0.000218	51,286	11	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,105	22,708,221	0.007359	447,693	3,295	54.00
60.00	06000	LABORATORY	71,590	7,596,194	0.009424	309,326	2,915	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	35,842	2,386,443	0.015019	160,388	2,409	65.00
66.00	06600	PHYSICAL THERAPY	99,659	1,610,653	0.061875	55,732	3,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,652	589,408	0.006196	64,807	402	67.00
68.00	06800	SPEECH PATHOLOGY	1,808	121,479	0.014883	12,174	181	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,944	2,009,534	0.006441	117,339	756	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,903	974,418	0.008110	243,336	1,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,487	8,004,355	0.008306	590,251	4,903	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	29,872	647,746	0.046117	0	0	90.01
91.00	09100	EMERGENCY	234,367	12,458,342	0.018812	18,186	342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	158,944	1,127,365	0.140987	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,243,405	79,431,987		2,474,127	28,504	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,462,158	0.000000	0.000000	403,609	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,898,296	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,837,375	0.000000	0.000000	51,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,708,221	0.000000	0.000000	447,693	54.00
60.00	06000	LABORATORY	0	7,596,194	0.000000	0.000000	309,326	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,386,443	0.000000	0.000000	160,388	65.00
66.00	06600	PHYSICAL THERAPY	0	1,610,653	0.000000	0.000000	55,732	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	589,408	0.000000	0.000000	64,807	67.00
68.00	06800	SPEECH PATHOLOGY	0	121,479	0.000000	0.000000	12,174	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,009,534	0.000000	0.000000	117,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	974,418	0.000000	0.000000	243,336	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,004,355	0.000000	0.000000	590,251	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	647,746	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	12,458,342	0.000000	0.000000	18,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,127,365	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	79,431,987			2,474,127	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.179023	0	1,517,149	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682702	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016585	0	189,080	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106909	0	5,499,222	0	0	54.00
60.00	06000	LABORATORY	0.201003	0	1,901,032	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.278535	0	125,067	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.590057	0	412,916	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.441801	0	99,564	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.099647	0	20,749	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241513	0	183,287	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.304160	0	139,935	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290926	0	2,484,830	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.723228	0	428,104	0	0	90.01
91.00	09100	EMERGENCY	0.294660	0	2,737,517	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.154921	0	999,520	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.573043		0			95.00
200.00		Subtotal (see instructions)		0	16,737,972	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	16,737,972	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 12:53 pm

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	271,605	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,136	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	587,916	0	54.00
60.00	06000	LABORATORY	382,113	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	34,836	0	65.00
66.00	06600	PHYSICAL THERAPY	243,644	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,987	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,817	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,266	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,563	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	722,902	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	309,617	0	90.01
91.00	09100	EMERGENCY	806,637	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,154,367	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,670,406	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,670,406	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1323 | Component CCN: 15-Z323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.179023	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682702	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016585	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106909	0	0	0	0	54.00
60.00	06000	LABORATORY	0.201003	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.278535	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.590057	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.441801	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.099647	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241513	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.304160	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290926	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.723228	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.294660	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.154921	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.573043		0			95.00
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: 15-1323 | Component CCN: 15-Z323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/30/2017 12:53 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	611,960	74,795	537,165	2,844	188.88	30.00
43.00	NURSERY	12,477		12,477	466	26.77	43.00
200.00	Total (lines 30-199)	624,437		549,642	3,310		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	25	4,722				30.00
43.00	NURSERY	141	3,775				43.00
200.00	Total (lines 30-199)	166	8,497				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	301,461	15,462,158	0.019497	73,776	1,438	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,370	1,898,296	0.027061	74,840	2,025	52.00
53.00	05300	ANESTHESIOLOGY	401	1,837,375	0.000218	16,574	4	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,105	22,708,221	0.007359	8,083	59	54.00
60.00	06000	LABORATORY	71,590	7,596,194	0.009424	18,286	172	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	35,842	2,386,443	0.015019	3,676	55	65.00
66.00	06600	PHYSICAL THERAPY	99,659	1,610,653	0.061875	153	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,652	589,408	0.006196	931	6	67.00
68.00	06800	SPEECH PATHOLOGY	1,808	121,479	0.014883	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,944	2,009,534	0.006441	6,757	44	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,903	974,418	0.008110	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,487	8,004,355	0.008306	20,756	172	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	29,872	647,746	0.046117	0	0	90.01
91.00	09100	EMERGENCY	234,367	12,458,342	0.018812	6,569	124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	159,979	1,127,365	0.141905	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,244,440	79,431,987		230,401	4,108	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,844	0.00	25	0		30.00
43.00	04300	NURSERY	466	0.00	141	0		43.00
200.00		Total (lines 30-199)	3,310		166	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,462,158	0.000000	0.000000	73,776	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,898,296	0.000000	0.000000	74,840	52.00
53.00	05300	ANESTHESIOLOGY	0	1,837,375	0.000000	0.000000	16,574	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,708,221	0.000000	0.000000	8,083	54.00
60.00	06000	LABORATORY	0	7,596,194	0.000000	0.000000	18,286	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,386,443	0.000000	0.000000	3,676	65.00
66.00	06600	PHYSICAL THERAPY	0	1,610,653	0.000000	0.000000	153	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	589,408	0.000000	0.000000	931	67.00
68.00	06800	SPEECH PATHOLOGY	0	121,479	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,009,534	0.000000	0.000000	6,757	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	974,418	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,004,355	0.000000	0.000000	20,756	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	647,746	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	12,458,342	0.000000	0.000000	6,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,127,365	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	79,431,987			230,401	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.179023	0	0	49,827	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682702	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016585	0	0	7,999	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106909	0	0	264,743	0	54.00
60.00	06000	LABORATORY	0.201003	0	0	97,733	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.278535	0	0	3,156	0	65.00
66.00	06600	PHYSICAL THERAPY	0.590057	0	0	1,867	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.441801	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.099647	0	0	1,165	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241513	0	0	4,685	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.304160	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290926	0	0	39,429	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.723228	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.294660	0	0	257,322	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.154921	0	0	35,819	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.573043	0	0			95.00
200.00		Subtotal (see instructions)		0	0	763,745	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	763,745	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,920		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	133		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,303		54.00
60.00	06000	LABORATORY	0	19,645		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	879		65.00
66.00	06600	PHYSICAL THERAPY	0	1,102		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,281		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,131		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,471		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	75,823		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	41,368		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	190,056		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	190,056		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,503	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,844	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)	1,997	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	396	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	263	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	762	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)	396	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	123.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,012,983	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)	32,433	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	641,168	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,371,815	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)	4,371,815	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)	1,537.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,171,354	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)	1,171,354	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)	582,151	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,753,505	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)	608,735	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	608,735	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)	847	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,537.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,302,017	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	611,960	5,012,983	0.122075	1,302,017	158,944	90.00
91.00	Nursing School cost	0	5,012,983	0.000000	1,302,017	0	91.00
92.00	Allied health cost	0	5,012,983	0.000000	1,302,017	0	92.00
93.00	All other Medical Education	0	5,012,983	0.000000	1,302,017	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,503	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,844	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)	1,997	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	396	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	263	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	25	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	466	15.00
16.00	Nursery days (title V or XIX only)	141	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,012,983	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	612,699	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,400,284	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)	4,400,284	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)	1,547.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	38,681	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)	38,681	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	373,599	466	801.71	141	113,041	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)	80,247	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	231,969	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)	8,497	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,108	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	12,605	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	219,364	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	847	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,547.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,310,495	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	611,960	5,012,983	0.122075	1,310,495	159,979	90.00
91.00	Nursing School cost	0	5,012,983	0.000000	1,310,495	0	91.00
92.00	Allied health cost	0	5,012,983	0.000000	1,310,495	0	92.00
93.00	All other Medical Education	0	5,012,983	0.000000	1,310,495	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,174,216		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.179023	403,609	72,255	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682702	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016585	51,286	851	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106909	447,693	47,862	54.00
60.00	06000	LABORATORY	0.201003	309,326	62,175	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.278535	160,388	44,674	65.00
66.00	06600	PHYSICAL THERAPY	0.590057	55,732	32,885	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.441801	64,807	28,632	67.00
68.00	06800	SPEECH PATHOLOGY	1.099647	12,174	13,387	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241513	117,339	28,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.304160	243,336	74,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290926	590,251	171,719	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.723228	0	0	90.01
91.00	09100	EMERGENCY	0.294660	18,186	5,359	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.154921	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,474,127	582,151	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)		2,474,127		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3

Component CCN: 15-Z323 | Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.179023	1,796	322	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682702	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016585	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106909	44,788	4,788	54.00
60.00	06000	LABORATORY	0.201003	59,016	11,862	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.278535	38,627	10,759	65.00
66.00	06600	PHYSICAL THERAPY	0.590057	86,214	50,871	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.441801	104,748	46,278	67.00
68.00	06800	SPEECH PATHOLOGY	1.099647	11,195	12,311	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241513	18,500	4,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.304160	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290926	193,344	56,249	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.723228	0	0	90.01
91.00	09100	EMERGENCY	0.294660	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.154921	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		558,228	197,908	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)		558,228		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/30/2017 12:53 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		14,010		30.00
43.00	04300	NURSERY		43,236		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.179023	73,776	13,208	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682702	74,840	51,093	52.00
53.00	05300	ANESTHESIOLOGY	0.016585	16,574	275	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106909	8,083	864	54.00
60.00	06000	LABORATORY	0.201003	18,286	3,676	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.278535	3,676	1,024	65.00
66.00	06600	PHYSICAL THERAPY	0.590057	153	90	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.441801	931	411	67.00
68.00	06800	SPEECH PATHOLOGY	1.099647	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.241513	6,757	1,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.304160	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290926	20,756	6,038	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0.723228	0	0	90.01
91.00	09100	EMERGENCY	0.294660	6,569	1,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.154921	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		230,401	80,247	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)		230,401		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1323	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 12:53 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,670,406	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,670,406	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,717,110	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	39,326	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,002,801	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)	1,674,983	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)	1,674,983	30.00
31.00	Primary payer payments	2,077	31.00
32.00	Subtotal (line 30 minus line 31)	1,672,906	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)	253,602	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	164,841	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	253,602	36.00
37.00	Subtotal (see instructions)	1,837,747	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,837,747	40.00
40.01	Sequestration adjustment (see instructions)	36,755	40.01
41.00	Interim payments	2,141,713	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-340,721	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,316,868		2,141,713	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,316,868		2,141,713	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		226,478		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		340,721	6.02
7.00	Total Medicare program liability (see instructions)		1,543,346		1,800,992	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: 15-1323 | Component CCN: 15-Z323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		631,010		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		631,010		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		167,405		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		798,415		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: 15-1323	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/30/2017 12:53 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,009	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	762	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	566	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,997	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	90,247,429	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,433,578	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	19,507	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	17,082	8.00
9.00	Sequestration adjustment amount (see instructions)	342	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	16,740	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	16,740	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1323 | Component CCN: 15-Z323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-2 | Date/Time Prepared: 5/30/2017 12:53 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	614,822	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)	199,887	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	396	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)	814,709	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	814,709	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)	814,709	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	814,709	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	814,709	0	19.00
19.01	Sequestration adjustment (see instructions)	16,294	0	19.01
20.00	Interim payments	631,010	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)	167,405	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1323	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/30/2017 12:53 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,753,505	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)	1,753,505	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,771,040	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)	1,771,040	19.00
20.00	Deductibles (exclude professional component)	243,959	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,527,081	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,527,081	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	73,480	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	47,762	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	73,480	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,574,843	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,574,843	30.00
30.01	Sequestration adjustment (see instructions)	31,497	30.01
31.00	Interim payments	1,316,868	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	226,478	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: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/30/2017 12:53 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	40,118	0	0	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	4,484,598	0	0	0	4.00
5.00	Other receivable	82,465	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	331,673	0	0	0	7.00
8.00	Prepaid expenses	93,569	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-2,619,007	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,413,416	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	282,529	0	0	0	12.00
13.00	Land improvements	1,972,720	0	0	0	13.00
14.00	Accumulated depreciation	-1,057,923	0	0	0	14.00
15.00	Buildings	13,429,858	0	0	0	15.00
16.00	Accumulated depreciation	-3,325,922	0	0	0	16.00
17.00	Leasehold improvements	29,098	0	0	0	17.00
18.00	Accumulated depreciation	-28,460	0	0	0	18.00
19.00	Fixed equipment	7,763,317	0	0	0	19.00
20.00	Accumulated depreciation	-4,631,472	0	0	0	20.00
21.00	Automobiles and trucks	154,457	0	0	0	21.00
22.00	Accumulated depreciation	-78,012	0	0	0	22.00
23.00	Major movable equipment	8,585,525	0	0	0	23.00
24.00	Accumulated depreciation	-5,863,836	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)	17,231,879	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	5,011,241	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,011,241	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,656,536	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,502,739	0	0	0	37.00
38.00	Salaries, wages, and fees payable	522,153	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	840,000	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	0	0	0	0	43.00
44.00	Other current liabilities	367,325	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,232,217	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	23,935,717	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,935,717	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	27,167,934	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-2,511,398				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		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)	-2,511,398	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,656,536	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/30/2017 12:53 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-2,511,398		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,135,762				2.00
3.00	Total (sum of line 1 and line 2)		624,364		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		624,364		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFERS.	3,135,762		0		0	13.00
14.00		0		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)		3,135,762		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-2,511,398		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	TRANSFERS.		0		13.00
14.00			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)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2017 12:53 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,576,020		3,576,020	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	375,260		375,260	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,951,280		3,951,280	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)	3,951,280		3,951,280	17.00
18.00	Ancillary services	13,202,446	0	13,202,446	18.00
19.00	Outpatient services	0	72,952,768	72,952,768	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	0	4,018,824	4,018,824	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
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)	17,153,726	76,971,592	94,125,318	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,824,326		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)		30,824,326		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1323 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/30/2017 12:53 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	94,125,318	1.00
2.00	Less contractual allowances and discounts on patients' accounts	61,398,131	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,727,187	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,824,326	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,902,861	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	140,919	6.00
7.00	Income from investments	-1,560	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	0	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	252,963	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	0	16.00
17.00	Revenue from sale of drugs to other than patients	395,853	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	12,688	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	32,535	22.00
23.00	Governmental appropriations	0	23.00
24.00	GAIN ON SALE OF ASSETS	14,836	24.00
24.01	COUNTY REIMBURSEMENT AMBULANCE SRV	349,000	24.01
24.02	MISCELLANEOUS	35,667	24.02
25.00	Total other income (sum of lines 6-24)	1,232,901	25.00
26.00	Total (line 5 plus line 25)	3,135,762	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,135,762	29.00