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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S Parts I-III | Date/Time Prepared: 11/22/2016 4:10 pm

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically filed cost report — Date: 11/22/2016 Time: 4:10 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 ST. VINCENT CLAY HOSPITAL (151309) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 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		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	262,409	-6,093	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	206,140	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	468,549	-6,093	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2016 2:58 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1206 EAST NATIONAL AVENUE	PO Box:			1.00
2.00	City: BRAZIL	State: IN	Zip Code: 47834	County: CLAY	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	ST. VINCENT CLAY HOSPITAL	151309	45460	1	08/08/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT CLAY SWING BEDS	15Z309	45460		08/08/2001	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
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	06/30/2016	20.00
21.00	Type of Control (see instructions)	1		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.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151309	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 2:58 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151309	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 2:58 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2016 2:58 pm

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

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

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

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

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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	46,679	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 2:58 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	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: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	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		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151309	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 2:58 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	
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. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2016 2:58 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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)	Y	10/18/2016	Y	10/18/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151309	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/22/2016 2:58 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.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	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.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519	JILL.HILL@STVINCENT.ORG	43.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2016 2:58 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	31,656.00	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	31,656.00	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						13.00
14.00	Total (see instructions)		25	9,150	31,656.00	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
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2016 2:58 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)	772	40	1,319			1.00
2.00	HMO and other (see instructions)	84	234				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	554	0	603			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	20			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,326	40	1,942			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)	1,326	40	1,942	0.00	101.47	14.00
15.00	CAH visits	11,860	477	35,819			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	101.47	27.00
28.00	Observation Bed Days		0	417			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2016 2:58 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	227	10	408	1.00
2.00	HMO and other (see instructions)			28	65		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	227	10	408	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 Date/Time Prepared: 11/22/2016 2:58 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)	0.270711	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,314,697	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	16,590,068	6.00
7.00	Medicaid cost (line 1 times line 6)	4,491,114	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)	3,176,417	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,176,417	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,990,721	820,768	2,811,489	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	538,910	222,191	761,101	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	538,910	222,191	761,101	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)	2,430,099	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	532,083	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,898,016	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	513,814	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,274,915	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,451,332	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/22/2016 2:58 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		496,287	496,287	-138,729	357,558	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		570,713	570,713	134,449	705,162	2.00
2.01	00201	CAP REL COSTS-MOB		209,475	209,475	0	209,475	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	215,674	1,585,633	1,801,307	0	1,801,307	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,794,123	1,988,538	3,782,661	6,788	3,789,449	5.00
7.00	00700	OPERATION OF PLANT	69,699	908,163	977,862	0	977,862	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,065	56,065	0	56,065	8.00
9.00	00900	HOUSEKEEPING	0	381,246	381,246	0	381,246	9.00
10.00	01000	DIETARY	0	386,931	386,931	-206,041	180,890	10.00
11.00	01100	CAFETERIA	0	0	0	206,041	206,041	11.00
13.00	01300	NURSING ADMINISTRATION	251,217	35,240	286,457	0	286,457	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	52,478	52,478	0	52,478	14.00
15.00	01500	PHARMACY	0	979,540	979,540	0	979,540	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	104,220	18,775	122,995	0	122,995	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	872,731	108,274	981,005	-6,048	974,957	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	419,374	377,001	796,375	-61,285	735,090	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	667,262	551,039	1,218,301	903	1,219,204	54.00
60.00	06000	LABORATORY	22,861	1,072,522	1,095,383	0	1,095,383	60.00
65.00	06500	RESPIRATORY THERAPY	136,464	25,061	161,525	-15,279	146,246	65.00
66.00	06600	PHYSICAL THERAPY	0	736,385	736,385	-137,176	599,209	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	136,706	136,706	67.00
68.00	06800	SPEECH PATHOLOGY	0	59,215	59,215	0	59,215	68.00
69.00	06900	ELECTROCARDIOLOGY	123,209	43,487	166,696	-3,975	162,721	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	115,228	115,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	247,020	247,020	0	247,020	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	813,224	848,317	1,661,541	-26,445	1,635,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,490,058	11,737,405	17,227,463	5,137	17,232,600	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	13,040	13,040	-5,137	7,903	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	80	0	80	0	80	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	672	672	0	672	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
200.00		TOTAL (SUM OF LINES 118-199)	5,490,138	11,751,117	17,241,255	0	17,241,255	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/22/2016 2:58 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	-87,167	270,391	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-100,240	604,922	2.00
2.01	00201	CAP REL COSTS-MOB	0	209,475	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	304,692	2,105,999	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	350,218	4,139,667	5.00
7.00	00700	OPERATION OF PLANT	-27,990	949,872	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,065	8.00
9.00	00900	HOUSEKEEPING	0	381,246	9.00
10.00	01000	DIETARY	0	180,890	10.00
11.00	01100	CAFETERIA	-31,665	174,376	11.00
13.00	01300	NURSING ADMINISTRATION	-100	286,357	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	52,478	14.00
15.00	01500	PHARMACY	-1,740	977,800	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,111	115,884	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,213	972,744	30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,715	732,375	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-37,635	1,181,569	54.00
60.00	06000	LABORATORY	0	1,095,383	60.00
65.00	06500	RESPIRATORY THERAPY	-63	146,183	65.00
66.00	06600	PHYSICAL THERAPY	-619	598,590	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	136,706	67.00
68.00	06800	SPEECH PATHOLOGY	0	59,215	68.00
69.00	06900	ELECTROCARDIOLOGY	-1,276	161,445	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	115,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	247,020	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-151,036	1,484,060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	203,340	17,435,940	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,903	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	80	193.02
193.03	19303	FOUNDATION	0	0	193.03
193.04	19304	MISSION SERVICES	0	672	193.04
193.05	19305	OTHER NON-REIMBURSABLE	81,886	81,886	193.05
193.06	19306	ENTERTAINMENT	0	0	193.06
193.07	19307	MARKETING	0	0	193.07
200.00		TOTAL (SUM OF LINES 118-199)	285,226	17,526,481	200.00

RECLASSIFICATIONS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/22/2016 2:58 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MEDICAL OFFICE BUILDING				
1.00	OCCUPATIONAL THERAPY	67.00	0	291	1.00
2.00	PHYSICAL THERAPY	66.00	0	1,435	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	903	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	2,508	4.00
	TOTALS		0	5,137	
	B - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,280	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	126,401	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	130,681	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	0	206,041	1.00
	TOTALS		0	206,041	
	D - PROPERTY INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,048	1.00
	TOTALS		0	8,048	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	99,949	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
	TOTALS		0	99,949	
	F - OT RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	0	136,415	1.00
	TOTALS		0	136,415	
	G - OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15,279	1.00
	TOTALS		0	15,279	
500.00	Grand Total: Increases		0	601,550	500.00

RECLASSIFICATIONS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/22/2016 2:58 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL OFFICE BUILDING						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,137	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	5,137			
	B - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,280	11		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	126,401	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	130,681			
	C - CAFETERIA						
1.00	DIETARY	10.00	0	206,041	0		1.00
	TOTALS		0	206,041			
	D - PROPERTY INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,048	11		1.00
	TOTALS		0	8,048			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	6,048	0		1.00
2.00	OPERATING ROOM	50.00	0	61,285	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	2,196	0		3.00
4.00	EMERGENCY	91.00	0	26,445	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	3,975	0		5.00
	TOTALS		0	99,949			
	F - OT RECLASS						
1.00	PHYSICAL THERAPY	66.00	0	136,415	0		1.00
	TOTALS		0	136,415			
	G - OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	15,279	0		1.00
	TOTALS		0	15,279			
500.00	Grand Total: Decreases		0	601,550			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I Date/Time Prepared: 11/22/2016 2:58 pm

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,500	0	0	0	0	1.00
2.00	Land Improvements	192,578	0	0	0	0	2.00
3.00	Buildings and Fixtures	8,881,989	55,872	0	55,872	0	3.00
4.00	Building Improvements	983,009	12,031	0	12,031	0	4.00
5.00	Fixed Equipment	2,874,412	2,942	0	2,942	0	5.00
6.00	Movable Equipment	6,589,201	662,972	0	662,972	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,523,689	733,817	0	733,817	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,523,689	733,817	0	733,817	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,500	0	1.00
2.00	Land Improvements	192,578	0	2.00
3.00	Buildings and Fixtures	8,937,861	0	3.00
4.00	Building Improvements	995,040	0	4.00
5.00	Fixed Equipment	2,877,354	0	5.00
6.00	Movable Equipment	7,252,173	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,257,506	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	20,257,506	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II Date/Time Prepared: 11/22/2016 2:58 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	240,641	0	255,646	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	458,039	112,359	0	315	0	2.00
2.01	CAP REL COSTS-MOB	0	209,475	0	0	0	2.01
3.00	Total (sum of lines 1-2)	698,680	321,834	255,646	315	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	496,287	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	570,713	2.00
2.01	CAP REL COSTS-MOB	0	209,475	2.01
3.00	Total (sum of lines 1-2)	0	1,276,475	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2016 2:58 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	13,005,333	0	13,005,333	0.642001	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,252,173	0	7,252,173	0.357999	0	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	20,257,506	0	20,257,506	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	153,474	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	357,799	112,359	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0	209,475	2.01
3.00	Total (sum of lines 1-2)	0	0	0	511,273	321,834	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	116,917	0	0	0	270,391	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	134,449	315	0	0	604,922	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0	209,475	2.01
3.00	Total (sum of lines 1-2)	251,366	315	0	0	1,084,788	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/22/2016 2:58 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	-79,172	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-91,046	CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
2.01	Investment income - CAP REL COSTS-MOB (chapter 2)		0	CAP REL COSTS-MOB	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-3,082	ADMINISTRATIVE & GENERAL	5.00	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)	A	-1,017	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,529	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	-170,720			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	988,749			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-31,665	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	B	-1,700	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,111	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB		0	CAP REL COSTS-MOB	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	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
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/22/2016 2:58 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ACCRUED INCENTIVE	A	-201,569	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	ACCRUED INCENTIVE	A	247,422	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISC. INCOME - A&G	B	-71	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	DONATIONS	A	-100	NURSING ADMINISTRATION	13.00	0	33.03
33.04	ENTERTAINMENT	A	-439	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISC. INCOME - GENERAL RADIOLOGY	B	-328	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	MARKETING	A	-2,237	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING	A	-260	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	LOBBYING	A	-872	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	DONATIONS	A	-13,090	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MARKETING	A	-619	PHYSICAL THERAPY	66.00	0	33.10
33.11	NON-REIMBURSABLE ENTERTAINMENT	A	-850	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PROVIDER TAX	B	-343,468	ADMINISTRATIVE & GENERAL	5.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		285,226				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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2016 2:58 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	1,795,431	878,206	1.00
2.00	193.05	OTHER NON-REIMBURSABLE	HOME OFFICE	81,886	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION CHARGEBACK	300,561	300,561	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACK	1,354,243	1,354,243	3.01
3.02	0.00			0	0	3.02
4.00	7.00	OPERATION OF PLANT	ASCENSION CHARGEBACK	80,857	80,857	4.00
4.01	0.00			0	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	ASCENSION CHARGEBACK	52,690	52,690	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	ASCENSION CHARGEBACK	26,046	26,046	4.03
4.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF-INSURANCE	659,386	758,367	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	101,923	109,918	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION INTEREST	117,207	126,401	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	3,968	4,280	4.07
4.08	7.00	OPERATION OF PLANT	TRIMEDX	463,722	490,183	4.08
4.09	15.00	PHARMACY	TRIMEDX	707	747	4.09
4.10	30.00	ADULTS & PEDIATRICS	TRIMEDX	38,786	40,999	4.10
4.11	50.00	OPERATING ROOM	TRIMEDX	47,574	50,289	4.11
4.12	54.00	RADIOLOGY-DIAGNOSTIC	TRIMEDX	286,117	302,444	4.12
4.13	65.00	RESPIRATORY THERAPY	TRIMEDX	1,104	1,167	4.13
4.14	69.00	ELECTROCARDIOLOGY	TRIMEDX	22,352	23,628	4.14
4.15	91.00	EMERGENCY	TRIMEDX	18,156	19,192	4.15
4.16	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	184,239	27,988	4.16
5.00	0		0	5,636,955	4,648,206	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.

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	B	ST. VINCENT HOS	100.00	ST. VINCENT HOS	100.00	7.00
8.00	G	ASCENSION	100.00	ASCENSION	100.00	8.00
9.00	A	TRIMEDX	0.00	TRIMEDX	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2016 2:58 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	917,225	0	1.00
2.00	81,886	0	2.00
3.00	0	0	3.00
3.01	0	0	3.01
3.02	0	0	3.02
4.00	0	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	-98,981	0	4.04
4.05	-7,995	9	4.05
4.06	-9,194	9	4.06
4.07	-312	0	4.07
4.08	-26,461	0	4.08
4.09	-40	0	4.09
4.10	-2,213	0	4.10
4.11	-2,715	0	4.11
4.12	-16,327	0	4.12
4.13	-63	0	4.13
4.14	-1,276	0	4.14
4.15	-1,036	0	4.15
4.16	156,251	0	4.16
5.00	988,749		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	ADMINISTRATION	6.00
7.00	HOSPITAL	7.00
8.00	ADMINISTRATION	8.00
9.00	TECHNOLOGY MGMT	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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2016 2:58 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	559,195	0	559,195	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	20,720	20,720	0	0	0	2.00
3.00	91.00	EMERGENCY	150,000	150,000	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		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			729,915	170,720	559,195		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	0		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	20,720		2.00
3.00	91.00	EMERGENCY	0	0	0	150,000		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		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	170,720		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2016 2:58 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					316	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					9	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.21	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,371.00	3,468.00	3,751.00	4,460.00	0.00	9.00
10.00	AHSEA (see instructions)	91.57	79.63	51.76	25.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.82	39.82	25.88			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	125,542	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	276,157	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	194,152	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	595,851	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	111,500	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	707,351	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	707,351	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	12,583	24.00
25.00	Assistants (line 4 times column 3, line 11)	233	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	12,816	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,693	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	14,509	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	14,509	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2016 2:58 pm

Physical Therapy | Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.63	51.76	25.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	707,351	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	14,509	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	721,860	63.00
64.00	Total cost of outside supplier services (from your records)	586,319	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	12,816	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,693	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	14,509	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,693	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,693	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2016 2:58 pm

Occupational Therapy — Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	261	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.21	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,105.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.48	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.74	37.74	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	158,885	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	158,885	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	158,885	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	158,885	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	9,850	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	9,850	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,360	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	11,210	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	11,210	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2016 2:58 pm

Occupational Therapy — Cost

		1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.48	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	158,885	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	11,210	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	170,095	63.00
64.00	Total cost of outside supplier services (from your records)	136,415	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	9,850	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,360	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	11,210	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,360	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,360	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

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Speech Pathology | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	168	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.21	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	881.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.55	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.28	36.28	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	63,917	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	63,917	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	63,917	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	63,917	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	6,095	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	6,095	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	875	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	6,970	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	6,970	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/22/2016 2:58 pm

Speech Pathology | Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.55	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	63,917	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	6,970	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	70,887	63.00
64.00	Total cost of outside supplier services (from your records)	59,215	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	6,095	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	875	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	6,970	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	875	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	875	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 2:58 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP	MOB		
			0	1.00	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	270,391	270,391				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	604,922		604,922			2.00
2.01	00201	CAP REL COSTS-MOB	209,475		0	209,475		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,105,999	0	0	0	2,105,999	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,139,667	100,966	225,516	43,315	716,361	5.00
7.00	00700	OPERATION OF PLANT	949,872	55,489	124,141	0	27,830	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,065	5,800	12,975	0	0	8.00
9.00	00900	HOUSEKEEPING	381,246	3,216	7,195	0	0	9.00
10.00	01000	DIETARY	180,890	7,144	15,983	0	0	10.00
11.00	01100	CAFETERIA	174,376	4,052	9,066	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	286,357	6,331	14,163	0	100,306	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,478	0	0	0	0	14.00
15.00	01500	PHARMACY	977,800	3,174	7,100	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,884	28,136	62,947	0	41,613	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	972,744	18,265	40,862	0	348,466	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	732,375	7,498	16,775	0	167,448	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,181,569	5,200	11,633	14,507	266,426	54.00
60.00	06000	LABORATORY	1,095,383	4,252	9,513	0	9,128	60.00
65.00	06500	RESPIRATORY THERAPY	146,183	5,128	11,472	0	54,488	65.00
66.00	06600	PHYSICAL THERAPY	598,590	0	0	27,725	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	136,706	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	59,215	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	161,445	0	0	0	49,195	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	115,228	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	247,020	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,484,060	15,045	33,659	0	324,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,435,940	269,696	603,000	85,547	2,105,967	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	695	1,555	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,903	0	0	123,928	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	80	0	367	0	32	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	672	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	81,886	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	17,526,481	270,391	604,922	209,475	2,105,999	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,225,825	5,225,825				5.00
7.00	00700	OPERATION OF PLANT	1,157,332	491,682	1,649,014			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,840	31,795	73,182	179,817		8.00
9.00	00900	HOUSEKEEPING	391,657	166,392	40,583	5,012	603,644	9.00
10.00	01000	DIETARY	204,017	86,675	90,143	0	0	10.00
11.00	01100	CAFETERIA	187,494	79,655	51,132	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	407,157	172,977	79,884	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,478	22,295	0	0	0	14.00
15.00	01500	PHARMACY	988,074	419,774	40,045	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	248,580	105,607	355,031	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,380,337	586,424	230,467	43,807	285,645	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	924,096	392,594	94,611	24,110	144,419	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,479,335	628,482	138,214	25,180	43,395	54.00
60.00	06000	LABORATORY	1,118,276	475,089	53,656	0	43,395	60.00
65.00	06500	RESPIRATORY THERAPY	217,271	92,306	64,701	0	0	65.00
66.00	06600	PHYSICAL THERAPY	626,315	266,084	138,752	12,647	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	136,706	58,078	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	59,215	25,157	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	210,640	89,489	0	3,693	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	115,228	48,954	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	247,020	104,944	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,857,470	789,132	189,843	56,450	43,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,309,363	5,133,585	1,640,244	170,899	560,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,250	956	8,770	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	131,831	56,007	0	8,918	43,395	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	479	203	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	672	285	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	81,886	34,789	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	17,526,481	5,225,825	1,649,014	179,817	603,644	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 2:58 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	380,835					10.00
11.00	01100	CAFETERIA	0	318,281				11.00
13.00	01300	NURSING ADMINISTRATION	0	16,749	676,767			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	74,773		14.00
15.00	01500	PHARMACY	0	0	0	0	1,447,893	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,050	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	380,835	85,617	283,769	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	37,193	82,126	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,459	0	0	0	54.00
60.00	06000	LABORATORY	0	4,975	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,892	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	10,000	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	74,773	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	1,447,893	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	70,346	310,872	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	380,835	318,281	676,767	74,773	1,447,893	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	380,835	318,281	676,767	74,773	1,447,893	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 2:58 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	729,268					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,910	3,317,811	0	3,317,811		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	91,714	1,790,863	0	1,790,863		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,203	2,606,268	0	2,606,268		54.00
60.00	06000	LABORATORY	124,859	1,820,250	0	1,820,250		60.00
65.00	06500	RESPIRATORY THERAPY	9,728	397,898	0	397,898		65.00
66.00	06600	PHYSICAL THERAPY	48,659	1,092,457	0	1,092,457		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	194,784	0	194,784		67.00
68.00	06800	SPEECH PATHOLOGY	2,001	86,373	0	86,373		68.00
69.00	06900	ELECTROCARDIOLOGY	25,444	339,266	0	339,266		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	238,955	0	238,955		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	351,964	0	351,964		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,447,893	0	1,447,893		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	153,750	3,471,258	0	3,471,258		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	729,268	17,156,040	0	17,156,040		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,976	0	11,976		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	240,151	0	240,151		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0		193.01
193.02	19302	PUBLIC RELATIONS	0	682	0	682		193.02
193.03	19303	FOUNDATION	0	0	0	0		193.03
193.04	19304	MISSION SERVICES	0	957	0	957		193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	116,675	0	116,675		193.05
193.06	19306	ENTERTAINMENT	0	0	0	0		193.06
193.07	19307	MARKETING	0	0	0	0		193.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	729,268	17,526,481	0	17,526,481		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/22/2016 2:58 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	MOB	Subtotal	
			0	1.00	2.00	2.01	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	297,887	100,966	225,516	43,315	667,684	5.00
7.00	00700	OPERATION OF PLANT	0	55,489	124,141	0	179,630	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,800	12,975	0	18,775	8.00
9.00	00900	HOUSEKEEPING	0	3,216	7,195	0	10,411	9.00
10.00	01000	DIETARY	0	7,144	15,983	0	23,127	10.00
11.00	01100	CAFETERIA	0	4,052	9,066	0	13,118	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,331	14,163	0	20,494	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	3,174	7,100	0	10,274	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,136	62,947	0	91,083	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	18,265	40,862	0	59,127	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,498	16,775	0	24,273	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,200	11,633	14,507	31,340	54.00
60.00	06000	LABORATORY	0	4,252	9,513	0	13,765	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,128	11,472	0	16,600	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	27,725	27,725	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	15,045	33,659	0	48,704	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	297,887	269,696	603,000	85,547	1,256,130	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	695	1,555	0	2,250	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	123,928	123,928	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	367	0	367	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	297,887	270,391	604,922	209,475	1,382,675	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/22/2016 2:58 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	667,684				5.00
7.00	00700	OPERATION OF PLANT	0	62,820	242,450			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,062	10,760	33,597		8.00
9.00	00900	HOUSEKEEPING	0	21,259	5,967	936	38,573	9.00
10.00	01000	DIETARY	0	11,074	13,254	0	0	10.00
11.00	01100	CAFETERIA	0	10,177	7,518	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	22,100	11,745	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,849	0	0	0	14.00
15.00	01500	PHARMACY	0	53,633	5,888	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,493	52,199	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	74,925	33,885	8,185	18,253	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	50,160	13,910	4,505	9,228	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	80,298	20,321	4,705	2,773	54.00
60.00	06000	LABORATORY	0	60,700	7,889	0	2,773	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,793	9,513	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	33,996	20,400	2,363	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,420	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,214	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,434	0	690	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,255	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,408	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	100,829	27,912	10,547	2,773	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	655,899	241,161	31,931	35,800	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	122	1,289	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,156	0	1,666	2,773	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	26	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	36	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	4,445	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	0	667,684	242,450	33,597	38,573	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/22/2016 2:58 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	47,455					10.00
11.00	01100	CAFETERIA	0	30,813				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,621	55,960			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,849		14.00
15.00	01500	PHARMACY	0	0	0	0	69,795	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,941	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,455	8,289	23,464	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,601	6,791	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,756	0	0	0	54.00
60.00	06000	LABORATORY	0	482	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,345	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	968	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,849	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	69,795	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	6,810	25,705	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,455	30,813	55,960	2,849	69,795	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	47,455	30,813	55,960	2,849	69,795	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/22/2016 2:58 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,716					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,904	282,487	0	282,487		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,960	132,428	0	132,428		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,536	195,729	0	195,729		54.00
60.00	06000	LABORATORY	27,174	112,783	0	112,783		60.00
65.00	06500	RESPIRATORY THERAPY	2,117	41,368	0	41,368		65.00
66.00	06600	PHYSICAL THERAPY	10,590	95,074	0	95,074		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,420	0	7,420		67.00
68.00	06800	SPEECH PATHOLOGY	435	3,649	0	3,649		68.00
69.00	06900	ELECTROCARDIOLOGY	5,538	18,630	0	18,630		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,104	0	9,104		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,408	0	13,408		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	69,795	0	69,795		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	33,462	256,742	0	256,742		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	158,716	1,238,617	0	1,238,617		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,661	0	3,661		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	135,523	0	135,523		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0		193.01
193.02	19302	PUBLIC RELATIONS	0	393	0	393		193.02
193.03	19303	FOUNDATION	0	0	0	0		193.03
193.04	19304	MISSION SERVICES	0	36	0	36		193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	4,445	0	4,445		193.05
193.06	19306	ENTERTAINMENT	0	0	0	0		193.06
193.07	19307	MARKETING	0	0	0	0		193.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	158,716	1,382,675	0	1,382,675		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 2:58 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	MOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	2.00	2.01	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,473					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		82,473				2.00
2.01	00201	CAP REL COSTS-MOB		0	25,341			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	5,274,464		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,796	30,746	5,240	1,794,123	-5,225,825	5.00
7.00	00700	OPERATION OF PLANT	16,925	16,925	0	69,699	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,769	1,769	0	0	0	8.00
9.00	00900	HOUSEKEEPING	981	981	0	0	0	9.00
10.00	01000	DIETARY	2,179	2,179	0	0	0	10.00
11.00	01100	CAFETERIA	1,236	1,236	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,931	1,931	0	251,217	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	968	968	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,582	8,582	0	104,220	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,571	5,571	0	872,731	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,287	2,287	0	419,374	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,586	1,586	1,755	667,262	0	54.00
60.00	06000	LABORATORY	1,297	1,297	0	22,861	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,564	1,564	0	136,464	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,354	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	123,209	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,589	4,589	0	813,224	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	82,261	82,211	10,349	5,274,384	-5,225,825	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	212	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	14,992	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	50	0	80	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	270,391	604,922	209,475	2,105,999		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.278540	7.334788	8.266248	0.399282		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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 2:58 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,300,656					5.00
7.00	00700	OPERATION OF PLANT	1,157,332	39,861				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,840	1,769	95,008			8.00
9.00	00900	HOUSEKEEPING	391,657	981	2,648	8,694		9.00
10.00	01000	DIETARY	204,017	2,179	0	0	100	10.00
11.00	01100	CAFETERIA	187,494	1,236	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	407,157	1,931	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,478	0	0	0	0	14.00
15.00	01500	PHARMACY	988,074	968	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	248,580	8,582	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,380,337	5,571	23,146	4,114	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	924,096	2,287	12,739	2,080	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,479,335	3,341	13,304	625	0	54.00
60.00	06000	LABORATORY	1,118,276	1,297	0	625	0	60.00
65.00	06500	RESPIRATORY THERAPY	217,271	1,564	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	626,315	3,354	6,682	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	136,706	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	59,215	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	210,640	0	1,951	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	115,228	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	247,020	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,857,470	4,589	29,826	625	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,083,538	39,649	90,296	8,069	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,250	212	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	131,831	0	4,712	625	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	479	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	672	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	81,886	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	5,225,825	1,649,014	179,817	603,644	380,835	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.424841	41.369108	1.892651	69.432252	3,808.350000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	667,684	242,450	33,597	38,573	47,455	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.054280	6.082386	0.353623	4.436738	474.550000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 2:58 pm

		Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	6,461					11.00
13.00	01300	NURSING ADMINISTRATION	340	4,145				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	100			14.00
15.00	01500	PHARMACY	0	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	407	0	0	0	56,867,740	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,738	1,738	0	0	3,190,110	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	755	503	0	0	7,151,736	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,207	0	0	0	18,107,277	54.00
60.00	06000	LABORATORY	101	0	0	0	9,736,343	60.00
65.00	06500	RESPIRATORY THERAPY	282	0	0	0	758,581	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,794,340	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	156,017	68.00
69.00	06900	ELECTROCARDIOLOGY	203	0	0	0	1,984,061	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	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	1,000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,428	1,904	0	0	11,989,275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,461	4,145	100	1,000	56,867,740	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
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)	318,281	676,767	74,773	1,447,893	729,268	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.261879	163.273100	747.730000	1,447.893000	0.012824	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,813	55,960	2,849	69,795	158,716	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.769076	13.500603	28.490000	69.795000	0.002791	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,317,811		3,317,811	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,790,863		1,790,863	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,606,268		2,606,268	0	0	54.00
60.00	06000	LABORATORY	1,820,250		1,820,250	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	397,898	0	397,898	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,092,457	0	1,092,457	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	194,784	0	194,784	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	86,373	0	86,373	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	339,266		339,266	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	238,955		238,955	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	351,964		351,964	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,447,893		1,447,893	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,471,258		3,471,258	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	591,027		591,027		0	92.00
200.00		Subtotal (see instructions)	17,747,067	0	17,747,067	0	0	200.00
201.00		Less Observation Beds	591,027		591,027		0	201.00
202.00		Total (see instructions)	17,156,040	0	17,156,040	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,489,898		2,489,898			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	539,283	6,612,453	7,151,736	0.250410	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	810,997	17,296,279	18,107,276	0.143935	0.000000	54.00
60.00	06000	LABORATORY	711,513	9,024,830	9,736,343	0.186954	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	519,567	239,014	758,581	0.524529	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	305,968	2,873,049	3,179,017	0.343646	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,523	434,799	615,322	0.316556	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	12,719	143,298	156,017	0.553613	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	207,914	1,776,147	1,984,061	0.170996	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	421,256	1,033,494	1,454,750	0.164258	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	232,881	867,517	1,100,398	0.319852	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,136,905	2,814,190	3,951,095	0.366454	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	300,098	11,689,177	11,989,275	0.289530	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	48,431	651,781	700,212	0.844069	0.000000	92.00
200.00		Subtotal (see instructions)	7,917,953	55,456,028	63,373,981			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,917,953	55,456,028	63,373,981			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/22/2016 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/22/2016 2:58 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,317,811		3,317,811	0	3,317,811	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,790,863		1,790,863	0	1,790,863	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,606,268		2,606,268	0	2,606,268	54.00
60.00	06000	LABORATORY	1,820,250		1,820,250	0	1,820,250	60.00
65.00	06500	RESPIRATORY THERAPY	397,898	0	397,898	0	397,898	65.00
66.00	06600	PHYSICAL THERAPY	1,092,457	0	1,092,457	0	1,092,457	66.00
67.00	06700	OCCUPATIONAL THERAPY	194,784	0	194,784	0	194,784	67.00
68.00	06800	SPEECH PATHOLOGY	86,373	0	86,373	0	86,373	68.00
69.00	06900	ELECTROCARDIOLOGY	339,266		339,266	0	339,266	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	238,955		238,955	0	238,955	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	351,964		351,964	0	351,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,447,893		1,447,893	0	1,447,893	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,471,258		3,471,258	0	3,471,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	591,027		591,027		591,027	92.00
200.00		Subtotal (see instructions)	17,747,067	0	17,747,067	0	17,747,067	200.00
201.00		Less Observation Beds	591,027		591,027		591,027	201.00
202.00		Total (see instructions)	17,156,040	0	17,156,040	0	17,156,040	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/22/2016 2:58 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,489,898		2,489,898			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	539,283	6,612,453	7,151,736	0.250410	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	810,997	17,296,279	18,107,276	0.143935	0.000000	54.00
60.00	06000	LABORATORY	711,513	9,024,830	9,736,343	0.186954	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	519,567	239,014	758,581	0.524529	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	305,968	2,873,049	3,179,017	0.343646	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,523	434,799	615,322	0.316556	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	12,719	143,298	156,017	0.553613	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	207,914	1,776,147	1,984,061	0.170996	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	421,256	1,033,494	1,454,750	0.164258	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	232,881	867,517	1,100,398	0.319852	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,136,905	2,814,190	3,951,095	0.366454	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	300,098	11,689,177	11,989,275	0.289530	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	48,431	651,781	700,212	0.844069	0.000000	92.00
200.00		Subtotal (see instructions)	7,917,953	55,456,028	63,373,981			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,917,953	55,456,028	63,373,981			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/22/2016 2:58 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151309	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/22/2016 2:58 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	132,428	7,151,736	0.018517	209,876	3,886	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,729	18,107,276	0.010809	317,297	3,430	54.00
60.00	06000	LABORATORY	112,783	9,736,343	0.011584	385,993	4,471	60.00
65.00	06500	RESPIRATORY THERAPY	41,368	758,581	0.054533	229,585	12,520	65.00
66.00	06600	PHYSICAL THERAPY	95,074	3,179,017	0.029907	73,620	2,202	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,420	615,322	0.012059	32,986	398	67.00
68.00	06800	SPEECH PATHOLOGY	3,649	156,017	0.023388	5,905	138	68.00
69.00	06900	ELECTROCARDIOLOGY	18,630	1,984,061	0.009390	92,329	867	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,104	1,454,750	0.006258	184,160	1,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,408	1,100,398	0.012185	98,754	1,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,795	3,951,095	0.017665	490,993	8,673	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	256,742	11,989,275	0.021414	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	50,322	700,212	0.071867	0	0	92.00
200.00		Total (lines 50-199)	1,006,452	60,884,083		2,121,498	38,940	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/22/2016 2:58 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
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/22/2016 2:58 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	7,151,736	0.000000	0.000000	209,876	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,107,276	0.000000	0.000000	317,297	54.00
60.00	06000	LABORATORY	0	9,736,343	0.000000	0.000000	385,993	60.00
65.00	06500	RESPIRATORY THERAPY	0	758,581	0.000000	0.000000	229,585	65.00
66.00	06600	PHYSICAL THERAPY	0	3,179,017	0.000000	0.000000	73,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	615,322	0.000000	0.000000	32,986	67.00
68.00	06800	SPEECH PATHOLOGY	0	156,017	0.000000	0.000000	5,905	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,984,061	0.000000	0.000000	92,329	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,454,750	0.000000	0.000000	184,160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,100,398	0.000000	0.000000	98,754	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,951,095	0.000000	0.000000	490,993	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	11,989,275	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	700,212	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	60,884,083			2,121,498	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/22/2016 2:58 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
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/22/2016 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.250410	0	2,279,066	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143935	0	5,296,549	0	0	54.00
60.00	06000	LABORATORY	0.186954	0	3,387,002	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.524529	0	74,083	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.343646	0	904,813	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.316556	0	90,155	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.553613	0	14,824	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170996	0	311,450	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164258	0	376,999	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319852	0	395,730	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.366454	0	1,255,718	6,487	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.289530	0	2,729,390	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.844069	0	296,920	0	0	92.00
200.00		Subtotal (see instructions)		0	17,412,699	6,487	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	17,412,699	6,487	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/22/2016 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	570,701	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	762,359	0	54.00
60.00	06000	LABORATORY	633,214	0	60.00
65.00	06500	RESPIRATORY THERAPY	38,859	0	65.00
66.00	06600	PHYSICAL THERAPY	310,935	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,539	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,207	0	68.00
69.00	06900	ELECTROCARDIOLOGY	53,257	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,925	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,575	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	460,163	2,377	73.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	790,240	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	250,621	0	92.00
200.00		Subtotal (see instructions)	4,095,595	2,377	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,095,595	2,377	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V
Component CCN: 15Z309 | | Date/Time Prepared: 11/22/2016 2:58 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	0.250410	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143935	0	0	0	0	54.00
60.00	06000	LABORATORY	0.186954	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.524529	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.343646	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.316556	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.553613	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170996	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164258	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319852	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.366454	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.289530	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.844069	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151309 | Component CCN: 15Z309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/22/2016 2:58 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151309	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/22/2016 2:58 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)	2,359	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,736	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)	1,319	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	302	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)	301	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	20	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)	772	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)	302	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)	252	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	134.09	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.09	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,317,811	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)	2,682	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)	857,332	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,460,479	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,460,479	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)	1,417.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,094,179	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)	1,094,179	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151309	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/22/2016 2:58 pm
	Title XVIII	Hospital	Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	587,373	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,681,552	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)	428,034	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	357,167	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	785,201	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)	417	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,417.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	591,027	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151309

Period: From 07/01/2015 To 06/30/2016

Worksheet D-1

Date/Time Prepared: 11/22/2016 2:58 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	282,487	3,317,811	0.085143	591,027	50,322	90.00
91.00	Nursing School cost	0	3,317,811	0.000000	591,027	0	91.00
92.00	Allied health cost	0	3,317,811	0.000000	591,027	0	92.00
93.00	All other Medical Education	0	3,317,811	0.000000	591,027	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 2:58 pm

Title XIX | 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)	2,359	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,736	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)	1,319	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	302	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)	301	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	20	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)	40	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	134.09	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.09	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,317,811	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)	2,682	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)	857,332	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,460,479	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,460,479	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)	1,417.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	56,693	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)	56,693	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151309	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/22/2016 2:58 pm
	Title XIX	Hospital	Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	363,602	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	420,295	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)	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)	417	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,417.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	591,027	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 2:58 pm

Title XIX | 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	282,487	3,317,811	0.085143	591,027	50,322	90.00
91.00	Nursing School cost	0	3,317,811	0.000000	591,027	0	91.00
92.00	Allied health cost	0	3,317,811	0.000000	591,027	0	92.00
93.00	All other Medical Education	0	3,317,811	0.000000	591,027	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/22/2016 2:58 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		1,105,549		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.250410	209,876	52,555	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143935	317,297	45,670	54.00
60.00	06000	LABORATORY	0.186954	385,993	72,163	60.00
65.00	06500	RESPIRATORY THERAPY	0.524529	229,585	120,424	65.00
66.00	06600	PHYSICAL THERAPY	0.343646	73,620	25,299	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.316556	32,986	10,442	67.00
68.00	06800	SPEECH PATHOLOGY	0.553613	5,905	3,269	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170996	92,329	15,788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164258	184,160	30,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319852	98,754	31,587	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.366454	490,993	179,926	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.289530	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.844069	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,121,498	587,373	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)		2,121,498		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151309 Component CCN: 15Z309	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/22/2016 2:58 pm
	Title XVIII	Swing Beds - SNF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.250410	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143935	28,437	4,093	54.00
60.00	06000	LABORATORY	0.186954	88,135	16,477	60.00
65.00	06500	RESPIRATORY THERAPY	0.524529	88,579	46,462	65.00
66.00	06600	PHYSICAL THERAPY	0.343646	181,136	62,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.316556	127,354	40,315	67.00
68.00	06800	SPEECH PATHOLOGY	0.553613	4,289	2,374	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170996	1,788	306	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164258	68,835	11,307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319852	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.366454	155,875	57,121	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.289530	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.844069	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		744,428	240,702	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)		744,428		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/22/2016 2:58 pm

Title XIX | 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		432,253		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.250410	147,566	36,952	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143935	226,422	32,590	54.00
60.00	06000	LABORATORY	0.186954	184,918	34,571	60.00
65.00	06500	RESPIRATORY THERAPY	0.524529	106,842	56,042	65.00
66.00	06600	PHYSICAL THERAPY	0.343646	11,383	3,912	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.316556	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.553613	484	268	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170996	42,179	7,212	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164258	168,261	27,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319852	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.366454	261,490	95,824	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.289530	168,367	48,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.844069	23,512	19,846	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,341,424	363,602	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)		1,341,424		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151309	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/22/2016 2:58 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,097,972	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)	4,097,972	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)	4,138,952	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)	51,040	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,820,567	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)	1,267,345	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)	1,267,345	30.00
31.00	Primary payer payments	1,782	31.00
32.00	Subtotal (line 30 minus line 31)	1,265,563	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)	774,198	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	503,229	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	488,095	36.00
37.00	Subtotal (see instructions)	1,768,792	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		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)	1,768,792	40.00
40.01	Sequestration adjustment (see instructions)	35,376	40.01
41.00	Interim payments	1,739,509	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-6,093	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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 11/22/2016 2:58 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		1,226,595		1,739,509	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)		1,226,595		1,739,509	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		262,409		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		6,093	6.02
7.00	Total Medicare program liability (see instructions)		1,489,004		1,733,416	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: 151309 | Component CCN: 15Z309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2016 2:58 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		801,540		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)		801,540		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		206,140		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,007,680		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 - SWING BEDS

Provider CCN: 151309 | Component CCN: 15Z309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-2 | Date/Time Prepared: 11/22/2016 2:58 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)	793,053	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)	243,109	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	554	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)	1,036,162	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,036,162	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)	1,036,162	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,917	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)	1,028,245	0	15.00
16.00		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)	1,028,245	0	19.00
19.01	Sequestration adjustment (see instructions)	20,565	0	19.01
20.00	Interim payments	801,540	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)	206,140	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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-3 Part V | Date/Time Prepared: 11/22/2016 2:58 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,681,552	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)	1,681,552	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,698,368	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)	1,698,368	19.00
20.00	Deductibles (exclude professional component)	207,200	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,491,168	22.00
23.00	Coinsurance	630	23.00
24.00	Subtotal (line 22 minus line 23)	1,490,538	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	44,391	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	28,854	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,343	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,519,392	28.00
29.00		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)	1,519,392	30.00
30.01	Sequestration adjustment (see instructions)	30,388	30.01
31.00	Interim payments	1,226,595	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)	262,409	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-3 Part VII Date/Time Prepared: 11/22/2016 2:58 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	420,295		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	420,295	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	420,295	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	247,490		8.00
9.00	Ancillary service charges	1,341,424	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,588,914	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,588,914	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,168,619	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	420,295	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	420,295	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	420,295	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	420,295	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	420,295	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	420,295	0	40.00
41.00	Interim payments	420,295	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/22/2016 2:58 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	1,136,564	0	0	0	1.00
2.00	Temporary investments	154,551	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,288,436	0	0	0	4.00
5.00	Other receivable	980,084	9,000	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,088,351	0	0	0	6.00
7.00	Inventory	452,793	0	0	0	7.00
8.00	Prepaid expenses	262,547	0	0	0	8.00
9.00	Other current assets	-232,300	0	0	0	9.00
10.00	Due from other funds	37,138	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,991,462	9,000	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,500	0	0	0	12.00
13.00	Land improvements	192,578	0	0	0	13.00
14.00	Accumulated depreciation	-189,633	0	0	0	14.00
15.00	Buildings	8,937,861	0	0	0	15.00
16.00	Accumulated depreciation	-3,943,579	0	0	0	16.00
17.00	Leasehold improvements	995,040	0	0	0	17.00
18.00	Accumulated depreciation	-477,912	0	0	0	18.00
19.00	Fixed equipment	2,877,354	0	0	0	19.00
20.00	Accumulated depreciation	-2,385,137	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,252,173	0	0	0	23.00
24.00	Accumulated depreciation	-5,902,931	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)	7,358,314	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	34,525,910	1,749,934	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	34,525,910	1,749,934	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,875,686	1,758,934	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	733,519	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,177,767	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	100,603	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	990,844	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,002,733	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,573,406	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	135,322	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,708,728	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,711,461	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	36,164,225				52.00
53.00	Specific purpose fund		1,758,934			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)	36,164,225	1,758,934	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,875,686	1,758,934	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151309

Period: From 07/01/2015 To 06/30/2016

Worksheet G-1

Date/Time Prepared: 11/22/2016 2:58 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		36,545,779		1,779,536		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,813,968				2.00
3.00	Total (sum of line 1 and line 2)		39,359,747		1,779,536		3.00
4.00	PENSION COST ADJUSTMENT	-382,500		0		0	4.00
5.00	CONTRIBUTIONS	0		61,305		0	5.00
6.00	RESTRICTED INVEST. INCOME - HSD	0		6,613		0	6.00
7.00	RESTRICTED INVEST. INCOME NON-HSD	0		-8,840		0	7.00
8.00	TRANSFER FROM AFFLIATES	-2,804,022		0		0	8.00
9.00	ROUNDSING	0		9,000		0	9.00
10.00	Total additions (sum of line 4-9)		-3,186,522		68,078		10.00
11.00	Subtotal (line 3 plus line 10)		36,173,225		1,847,614		11.00
12.00	TRANSFER FROM AFFILIATES	0		28,735		0	12.00
13.00	UNREALIZED LOSSES- RESTRICTED HSD	0		45,362		0	13.00
14.00	UNREALIZED LOSSES RESTRICTED NON-HSD	0		14,583		0	14.00
15.00	ROUNDING	9,000		0		0	15.00
16.00	PENSION COST ADJUSTMENT	0		0		0	16.00
17.00	ROUNDING	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		9,000		88,680		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		36,164,225		1,758,934		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	PENSION COST ADJUSTMENT		0		4.00
5.00	CONTRIBUTIONS		0		5.00
6.00	RESTRICTED INVEST. INCOME - HSD		0		6.00
7.00	RESTRICTED INVEST. INCOME NON-HSD		0		7.00
8.00	TRANSFER FROM AFFLIATES		0		8.00
9.00	ROUNDSING		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	TRANSFER FROM AFFILIATES		0		12.00
13.00	UNREALIZED LOSSES- RESTRICTED HSD		0		13.00
14.00	UNREALIZED LOSSES RESTRICTED NON-HSD		0		14.00
15.00	ROUNDING		0		15.00
16.00	PENSION COST ADJUSTMENT		0		16.00
17.00	ROUNDING		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: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/22/2016 2:58 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,794,931		2,794,931	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,794,931		2,794,931	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,794,931		2,794,931	17.00
18.00	Ancillary services	5,059,133	42,844,985	47,904,118	18.00
19.00	Outpatient services	348,529	12,326,404	12,674,933	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,202,593	55,171,389	63,373,982	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,241,255		29.00
30.00		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)		17,241,255		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151309 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-3 | Date/Time Prepared: 11/22/2016 2:58 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	63,373,982	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,495,576	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,878,406	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,241,255	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,637,151	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-732	6.00
7.00	Income from investments	173,300	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	31,665	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	1,700	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	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	136,199	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC. INCOME	7,509	24.00
24.01	ASSETS RELEASED FROM RESTRICTION	28,735	24.01
24.02		0	24.02
24.03	UNREALIZED LOSS	-1,186,839	24.03
24.04		0	24.04
24.05		0	24.05
25.00	Total other income (sum of lines 6-24)	-808,463	25.00
26.00	Total (line 5 plus line 25)	2,828,688	26.00
27.00		0	27.00
27.01	FUNDRAISING EXPENSES	14,720	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	14,720	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,813,968	29.00