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: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/17/2016 10:08 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/17/2016 Time: 10:08 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 MERCY HOSPITAL (151308) 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	190,906	92,184	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	48,081	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	238,987	92,184	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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 9:21 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13311 SOUTH A ST.	PO Box:			1.00
2.00	City: ELWOOD	State: IN	Zip Code: 46036-	County: MADISON	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 MERCY HOSPITAL	151308	11300	1	07/01/2001	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	SWING BED - SNF	15Z308	11300		07/01/2001	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:	To:	
		1.00	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: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 9:21 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 9:21 am

		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

		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	Y	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.	N	N	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:	35,534	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: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 9:21 am

Line	Description	1.00	2.00	Line
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

Line	1.00	2.00	3.00	Line
	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: 08101	141.00
142.00	Street: 10330 N. MERIDIAN STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

Line	Description	1.00	2.00	Line
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

Line	Description	1.00	Line
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

Line	Description	Part A	Part B	Title V	Title XIX	Line
		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

Line	Description	1.00	Line
	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

Line	Description	Name	County	State	Zip Code	CBSA	FTE/Campus	Line
		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

Line	Description	1.00	Line
	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)		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: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 9:21 am

		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: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 9:21 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/03/2016	Y	10/03/2016	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: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 9:21 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	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.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 9:21 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2016 9:21 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	32,880.00	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	32,880.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	32,880.00	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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2016 9:21 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	699	9	1,370			1.00
2.00	HMO and other (see instructions)	252	191				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	148	0	159			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	6			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	847	9	1,535			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	847	9	1,535	0.00	128.71	14.00
15.00	CAH visits	11,137	564	33,874			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	128.71	27.00
28.00	Observation Bed Days		0	443			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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2016 9:21 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	189	56	397	1.00
2.00	HMO and other (see instructions)			66	5		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	189	56	397	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: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/17/2016 9:21 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.315418	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	832,629	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	15,918,288	6.00
7.00	Medicaid cost (line 1 times line 6)	5,020,915	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)	4,188,286	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)	4,188,286	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	2,860,238	969,519	3,829,757	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	902,171	305,804	1,207,975	21.00
22.00	Partial payment by patients approved for charity care	166,416	62,586	229,002	22.00
23.00	Cost of charity care (line 21 minus line 22)	735,755	243,218	978,973	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)	2,344,963	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	734,303	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,610,660	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	508,031	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,487,004	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,675,290	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		830,543	830,543	-6,250	824,293	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		479,533	479,533	0	479,533	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	50,990	1,954,505	2,005,495	0	2,005,495	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,723,727	2,064,415	3,788,142	6,250	3,794,392	5.00
7.00	00700	OPERATION OF PLANT	145,180	1,575,403	1,720,583	0	1,720,583	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	32,040	32,040	8.00
9.00	00900	HOUSEKEEPING	0	515,859	515,859	-32,040	483,819	9.00
10.00	01000	DIETARY	0	459,410	459,410	-278,801	180,609	10.00
11.00	01100	CAFETERIA	0	0	0	278,801	278,801	11.00
13.00	01300	NURSING ADMINISTRATION	205,930	17,197	223,127	0	223,127	13.00
15.00	01500	PHARMACY	356,408	3,528,835	3,885,243	0	3,885,243	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,975	72,648	152,623	0	152,623	16.00
17.00	01700	SOCIAL SERVICE	80,610	28,570	109,180	0	109,180	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	978,518	295,417	1,273,935	-7,937	1,265,998	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	382,800	229,179	611,979	-35,902	576,077	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	991,404	382,994	1,374,398	0	1,374,398	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,042,960	1,042,960	0	1,042,960	60.00
65.00	06500	RESPIRATORY THERAPY	495,763	71,199	566,962	-19,175	547,787	65.00
66.00	06600	PHYSICAL THERAPY	437,833	23,201	461,034	0	461,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,577	285	59,862	-63	59,799	67.00
68.00	06800	SPEECH PATHOLOGY	19,087	22,392	41,479	0	41,479	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	11,623	11,623	92,628	104,251	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	92,202	92,202	0	92,202	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	49,716	6,645	56,361	0	56,361	76.00
76.01	03480	ONCOLOGY	169,096	14,967	184,063	0	184,063	76.01
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	262,529	58,672	321,201	-10,868	310,333	90.00
91.00	09100	EMERGENCY	978,170	1,005,543	1,983,713	-18,683	1,965,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,467,313	14,784,197	22,251,510	0	22,251,510	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	260	260	0	260	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	7,467,313	14,784,457	22,251,770	0	22,251,770	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-102,004	722,289	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	479,533	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	745,089	2,750,584	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-16,947	3,777,445	5.00
7.00	00700	OPERATION OF PLANT	-52,439	1,668,144	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,040	8.00
9.00	00900	HOUSEKEEPING	0	483,819	9.00
10.00	01000	DIETARY	-64,917	115,692	10.00
11.00	01100	CAFETERIA	0	278,801	11.00
13.00	01300	NURSING ADMINISTRATION	0	223,127	13.00
15.00	01500	PHARMACY	-81,693	3,803,550	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,799	145,824	16.00
17.00	01700	SOCIAL SERVICE	0	109,180	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-209,555	1,056,443	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	576,077	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-334,689	1,039,709	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	-750	1,042,210	60.00
65.00	06500	RESPIRATORY THERAPY	0	547,787	65.00
66.00	06600	PHYSICAL THERAPY	-1,866	459,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	59,799	67.00
68.00	06800	SPEECH PATHOLOGY	0	41,479	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	-260	103,991	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	92,202	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03610	SLEEP LAB	-3,420	52,941	76.00
76.01	03480	ONCOLOGY	0	184,063	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	310,333	90.00
91.00	09100	EMERGENCY	-150,000	1,815,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	-280,250	21,971,260	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	MARKETING	118,860	118,860	194.00
194.01	07951	FOUNDATION	0	260	194.01
194.02	07952	CLINIC	0	0	194.02
194.03	07953	VACANT	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-161,390	22,090,380	200.00

RECLASSIFICATIONS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/17/2016 9:21 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	0	278,801	1.00
	TOTALS		0	278,801	
	B - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	32,040	1.00
	TOTALS		0	32,040	
	C - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,250	1.00
	TOTALS		0	6,250	
	D - BILLABLE MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	73,117	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	73,117	
	E - OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	19,511	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	19,511	
500.00	Grand Total: Increases		0	409,719	500.00

RECLASSIFICATIONS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/17/2016 9:21 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	278,801	0		1.00
	TOTALS		0	278,801			
	B - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	32,040	0		1.00
	TOTALS		0	32,040			
	C - INTEREST						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	6,250	9		1.00
	TOTALS		0	6,250			
	D - BILLABLE MED SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	7,937	0		1.00
2.00	OPERATING ROOM	50.00	0	35,566	0		2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	63	0		3.00
4.00	CLINIC	90.00	0	10,868	0		4.00
5.00	EMERGENCY	91.00	0	18,683	0		5.00
	TOTALS		0	73,117			
	E - OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	19,175	0		1.00
2.00	OPERATING ROOM	50.00	0	336	0		2.00
	TOTALS		0	19,511			
500.00	Grand Total: Decreases		0	409,719			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I Date/Time Prepared: 11/17/2016 9:21 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	457,300	0	0	0	0	1.00
2.00	Land Improvements	528,489	0	0	0	0	2.00
3.00	Buildings and Fixtures	26,966,544	828,661	0	828,661	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,952,333	828,661	0	828,661	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,952,333	828,661	0	828,661	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	457,300	0	1.00
2.00	Land Improvements	528,489	0	2.00
3.00	Buildings and Fixtures	27,795,205	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,780,994	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	28,780,994	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II Date/Time Prepared: 11/17/2016 9:21 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	830,543	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	479,533	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,310,076	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	830,543	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	479,533	2.00
3.00	Total (sum of lines 1-2)	0	1,310,076	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/17/2016 9:21 am

	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	NEW CAP REL COSTS-BLDG & FIXT	28,780,994	0	28,780,994	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	28,780,994	0	28,780,994	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	722,289	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	479,533	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,201,822	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	722,289	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	479,533	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,201,822	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/17/2016 9:21 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-76,899	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-1,393	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	-7,228	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,327	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-733,876			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	1,034,393			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-64,917	DIETARY	10.00	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	-81,693	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,799	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
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
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/17/2016 9:21 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00			0		0.00	0	33.00
33.01	LAB REVENUE	B	-750	LABORATORY	60.00	0	33.01
33.02	PT REVENUE	B	-1,866	PHYSICAL THERAPY	66.00	0	33.02
33.03	SUPPLIES REVENUE	B	-260	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.03
34.00	ADMIN REVENUE	B	-7,639	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00			0		0.00	0	35.00
35.01			0		0.00	0	35.01
36.00	LOBBYING	A	-926	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	INCENTIVE ADJUSTMENT	A	300,122	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
38.00	INCENTIVE ADJUSTMENT	A	-219,913	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	PHYSICIAN SUPPORT SERVICES	A	-849	ADULTS & PEDIATRICS	30.00	0	39.00
40.00	MARKETING AND COMMUNITY RELATIONS	A	-223	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	MARKETING AND COMMUNITY RELATIONS	A	-3,344	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	PROVIDER TAX	A	-302,347	ADMINISTRATIVE & GENERAL	5.00	0	42.00
42.04			0		0.00	0	42.04
42.05	MEDICAL AFFAIRS ADMIN	A	19,142	ADMINISTRATIVE & GENERAL	5.00	0	42.05
42.06	GIFTS/DONATIONS EXPENSE	A	-798	ADMINISTRATIVE & GENERAL	5.00	0	42.06
42.09			0		0.00	0	42.09
42.10			0		0.00	0	42.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-161,390				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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/17/2016 9:21 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,679,011	1,130,664	2.00
3.00	194.00	MARKETING	HOME OFFICE	118,860	0	3.00
3.01	0.00			0	0	3.01
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST. VINCENT HEALTH - CHG	407,995	407,995	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH - CHG	1,470,940	1,470,940	4.01
4.02	9.00	HOUSEKEEPING	ST. VINCENT HEALTH - CHG	-36,773	-36,773	4.02
4.03	10.00	DIETARY	ST. VINCENT HEALTH - CHG	-364	-364	4.03
4.04	13.00	NURSING ADMINISTRATION	ST. VINCENT HEALTH - CHG	26,489	26,489	4.04
4.05	15.00	PHARMACY	ST. VINCENT HEALTH - CHG	50,246	50,246	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HEALTH - CHG	88,133	88,133	4.06
4.07	30.00	ADULTS & PEDIATRICS	ST. VINCENT HEALTH - CHG	-1,965	-1,965	4.07
4.08	50.00	OPERATING ROOM	ST. VINCENT HEALTH - CHG	-3,045	-3,045	4.08
4.09	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HEALTH - CHG	29,946	29,946	4.09
4.10	65.00	RESPIRATORY THERAPY	ST. VINCENT HEALTH - CHG	21,775	21,775	4.10
4.11	76.01	ONCOLOGY	ST. VINCENT HEALTH - CHG	10,571	10,571	4.11
4.12	91.00	EMERGENCY	ST. VINCENT HEALTH - CHG	401	401	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	995,122	927,620	4.15
4.16	0.00			0	0	4.16
4.17	1.00	NEW CAP REL COSTS-BLDG & FIX	ASCENSION INTEREST	320,039	345,144	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	5,796	6,250	4.18
4.19	0.00			0	0	4.19
4.20	7.00	OPERATION OF PLANT	ASCENSION MAINTENACE	918,957	971,396	4.20
4.21	30.00	ADULTS & PEDIATRICS	ASCENSION MAINTENACE	99	105	4.21
4.22	0.00			0	0	4.22
4.23	4.00	EMPLOYEE BENEFITS DEPARTMENT	PENSION	311,692	-65,996	4.23
4.24	0.00			0	0	4.24
5.00	0		0	6,413,925	5,379,532	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	Related Organization(s) and/or Home Office: Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B	ST. VINCENT HEA	100.00	ST. VINCENT HEALTH	100.00	6.00
7.00	B	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	B	ST. VINCENT HOS	100.00	ST. VINCENT HOSPITAL	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:					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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/17/2016 9:21 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	548,347	0		2.00
3.00	118,860	0		3.00
3.01	0	0		3.01
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	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	67,502	0		4.15
4.16	0	0		4.16
4.17	-25,105	9		4.17
4.18	-454	0		4.18
4.19	0	0		4.19
4.20	-52,439	0		4.20
4.21	-6	0		4.21
4.22	0	0		4.22
4.23	377,688	0		4.23
4.24	0	0		4.24
5.00	1,034,393			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	ADMINISTRATION		7.00
8.00	HOSPITAL		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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/17/2016 9:21 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	37,067	37,067	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	208,700	208,700	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	334,689	334,689	0	0	0	3.00
4.00	76.00	SLEEP LAB	3,420	3,420	0	0	0	4.00
5.00	91.00	EMERGENCY	713,934	0	713,934	0	0	5.00
6.00	91.00	EMERGENCY	150,000	150,000	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			1,447,810	733,876	713,934		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	76.00	SLEEP LAB	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	37,067		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	208,700		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	334,689		3.00
4.00	76.00	SLEEP LAB	0	0	0	3,420		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	91.00	EMERGENCY	0	0	0	150,000		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	733,876		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/17/2016 9:21 am

Speech Pathology | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	29	1.00
2.00	Line 1 multiplied by 15 hours per week	435	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	146	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	415.50	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)	30,145	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)	30,145	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)	30,145	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)	72.55	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	31,559	22.00
23.00	Total salary equivalency (see instructions)	31,559	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)	5,297	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)	5,297	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)	761	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	6,058	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)	0	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: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/17/2016 9:21 am
		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)	31,559	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	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)	31,559	63.00
64.00	Total cost of outside supplier services (from your records)	27,191	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	5,297	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	761	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	6,058	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	761	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	761	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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	722,289	722,289				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	479,533		479,533			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,750,584	5,170	0	2,755,754		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,777,445	267,081	18,973	640,499	4,703,998	5.00
7.00	00700	OPERATION OF PLANT	1,668,144	112,047	200,930	53,946	2,035,067	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,040	8,604	0	0	40,644	8.00
9.00	00900	HOUSEKEEPING	483,819	5,244	0	0	489,063	9.00
10.00	01000	DIETARY	115,692	14,268	2,343	0	132,303	10.00
11.00	01100	CAFETERIA	278,801	9,049	0	0	287,850	11.00
13.00	01300	NURSING ADMINISTRATION	223,127	10,426	597	76,519	310,669	13.00
15.00	01500	PHARMACY	3,803,550	8,023	15,897	132,434	3,959,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	145,824	12,569	0	29,717	188,110	16.00
17.00	01700	SOCIAL SERVICE	109,180	2,477	0	29,953	141,610	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,056,443	49,165	37,045	363,598	1,506,251	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	576,077	48,269	78,372	142,241	844,959	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,039,709	30,987	87,972	368,386	1,527,054	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,042,210	13,570	1,148	0	1,056,928	60.00
65.00	06500	RESPIRATORY THERAPY	547,787	10,586	9,730	184,216	752,319	65.00
66.00	06600	PHYSICAL THERAPY	459,168	31,834	406	162,690	654,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,799	1,124	0	22,138	83,061	67.00
68.00	06800	SPEECH PATHOLOGY	41,479	0	0	7,092	48,571	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	103,991	0	0	0	103,991	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	92,202	0	0	0	92,202	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	52,941	4,509	3,452	18,473	79,375	76.00
76.01	03480	ONCOLOGY	184,063	2,137	0	62,833	249,033	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	310,333	8,937	0	97,551	416,821	90.00
91.00	09100	EMERGENCY	1,815,030	44,576	22,668	363,468	2,245,742	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)	21,971,260	700,652	479,533	2,755,754	21,949,623	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,094	0	0	2,094	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,845	0	0	8,845	192.00
194.00	07950	MARKETING	118,860	4,540	0	0	123,400	194.00
194.01	07951	FOUNDATION	260	1,921	0	0	2,181	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	4,237	0	0	4,237	194.03
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)	22,090,380	722,289	479,533	2,755,754	22,090,380	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,703,998					5.00
7.00	00700	OPERATION OF PLANT	550,600	2,585,667				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,996	65,821	117,461			8.00
9.00	00900	HOUSEKEEPING	132,319	40,116	22,716	684,214		9.00
10.00	01000	DIETARY	35,795	109,150	39	0	277,287	10.00
11.00	01100	CAFETERIA	77,880	69,223	60	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	84,053	79,760	0	2,756	0	13.00
15.00	01500	PHARMACY	1,071,386	61,379	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	50,894	96,156	0	7,086	0	16.00
17.00	01700	SOCIAL SERVICE	38,313	18,948	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	407,525	376,118	36,103	107,868	277,287	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	228,609	369,266	11,556	105,900	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	413,154	237,058	12,143	59,839	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	285,958	103,810	0	29,526	0	60.00
65.00	06500	RESPIRATORY THERAPY	203,544	80,988	0	27,164	0	65.00
66.00	06600	PHYSICAL THERAPY	176,970	243,531	9,287	154,716	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,473	8,600	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,141	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	28,135	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	24,946	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,267	0	73.00
76.00	03610	SLEEP LAB	21,475	34,493	947	16,141	0	76.00
76.01	03480	ONCOLOGY	67,377	16,349	0	13,385	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	112,773	68,372	96	12,598	0	90.00
91.00	09100	EMERGENCY	607,599	341,010	24,514	137,000	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)	4,665,915	2,420,148	117,461	682,246	277,287	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	567	16,018	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,393	67,663	0	0	0	192.00
194.00	07950	MARKETING	33,387	34,729	0	787	0	194.00
194.01	07951	FOUNDATION	590	14,695	0	1,181	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	1,146	32,414	0	0	0	194.03
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)	4,703,998	2,585,667	117,461	684,214	277,287	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
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	435,013					11.00
13.00	01300	NURSING ADMINISTRATION	11,735	488,973				13.00
15.00	01500	PHARMACY	0	0	5,092,669			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,790	0	0	355,036		16.00
17.00	01700	SOCIAL SERVICE	5,162	6,220	0	0	210,253	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91,108	109,770	0	17,109	203,933	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,910	37,247	0	44,655	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,266	84,672	0	95,585	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	50,823	0	60.00
65.00	06500	RESPIRATORY THERAPY	40,033	48,241	0	15,018	0	65.00
66.00	06600	PHYSICAL THERAPY	33,451	40,309	0	15,517	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,287	3,961	0	1,551	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,367	88	0	1,158	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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,063	21,766	5,092,669	0	0	73.00
76.00	03610	SLEEP LAB	2,932	3,533	0	1,882	0	76.00
76.01	03480	ONCOLOGY	10,899	13,133	0	7,126	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,548	27,170	0	7,515	0	90.00
91.00	09100	EMERGENCY	77,064	92,863	0	97,097	6,320	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	431,615	488,973	5,092,669	355,036	210,253	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	3,398	0	0	0	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	0	0	0	0	194.03
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)	435,013	488,973	5,092,669	355,036	210,253	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,133,072	0	3,133,072	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,673,102	0	1,673,102	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,499,771	0	2,499,771	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	1,527,045	0	1,527,045	60.00
65.00	06500	RESPIRATORY THERAPY	1,167,307	0	1,167,307	65.00
66.00	06600	PHYSICAL THERAPY	1,327,879	0	1,327,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,933	0	122,933	67.00
68.00	06800	SPEECH PATHOLOGY	64,325	0	64,325	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	132,126	0	132,126	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	117,148	0	117,148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,140,765	0	5,140,765	73.00
76.00	03610	SLEEP LAB	160,778	0	160,778	76.00
76.01	03480	ONCOLOGY	377,302	0	377,302	76.01
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	667,893	0	667,893	90.00
91.00	09100	EMERGENCY	3,629,209	0	3,629,209	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)	21,740,655	0	21,740,655	118.00
	NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,679	0	18,679	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	78,901	0	78,901	192.00
194.00	07950	MARKETING	192,303	0	192,303	194.00
194.01	07951	FOUNDATION	22,045	0	22,045	194.01
194.02	07952	CLINIC	0	0	0	194.02
194.03	07953	VACANT	37,797	0	37,797	194.03
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,090,380	0	22,090,380	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,170	0	5,170	5,170	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	377,675	267,081	18,973	663,729	1,201	5.00
7.00	00700	OPERATION OF PLANT	0	112,047	200,930	312,977	101	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,604	0	8,604	0	8.00
9.00	00900	HOUSEKEEPING	0	5,244	0	5,244	0	9.00
10.00	01000	DIETARY	0	14,268	2,343	16,611	0	10.00
11.00	01100	CAFETERIA	0	9,049	0	9,049	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,426	597	11,023	144	13.00
15.00	01500	PHARMACY	0	8,023	15,897	23,920	248	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,569	0	12,569	56	16.00
17.00	01700	SOCIAL SERVICE	0	2,477	0	2,477	56	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	49,165	37,045	86,210	682	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	48,269	78,372	126,641	267	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,987	87,972	118,959	691	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	13,570	1,148	14,718	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,586	9,730	20,316	346	65.00
66.00	06600	PHYSICAL THERAPY	0	31,834	406	32,240	305	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,124	0	1,124	42	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	13	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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	4,509	3,452	7,961	35	76.00
76.01	03480	ONCOLOGY	0	2,137	0	2,137	118	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,937	0	8,937	183	90.00
91.00	09100	EMERGENCY	0	44,576	22,668	67,244	682	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)	377,675	700,652	479,533	1,557,860	5,170	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,094	0	2,094	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,845	0	8,845	0	192.00
194.00	07950	MARKETING	0	4,540	0	4,540	0	194.00
194.01	07951	FOUNDATION	0	1,921	0	1,921	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	4,237	0	4,237	0	194.03
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)	377,675	722,289	479,533	1,579,497	5,170	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	664,930					5.00
7.00	00700	OPERATION OF PLANT	77,829	390,907				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,554	9,951	20,109			8.00
9.00	00900	HOUSEKEEPING	18,704	6,065	3,889	33,902		9.00
10.00	01000	DIETARY	5,060	16,502	7	0	38,180	10.00
11.00	01100	CAFETERIA	11,009	10,465	10	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,881	12,058	0	137	0	13.00
15.00	01500	PHARMACY	151,447	9,279	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,194	14,537	0	351	0	16.00
17.00	01700	SOCIAL SERVICE	5,416	2,865	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	57,605	56,860	6,181	5,345	38,180	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,315	55,827	1,978	5,247	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,401	35,839	2,079	2,965	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	40,421	15,694	0	1,463	0	60.00
65.00	06500	RESPIRATORY THERAPY	28,772	12,244	0	1,346	0	65.00
66.00	06600	PHYSICAL THERAPY	25,015	36,818	1,590	7,665	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,177	1,300	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,858	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	3,977	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,526	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	410	0	73.00
76.00	03610	SLEEP LAB	3,036	5,215	162	800	0	76.00
76.01	03480	ONCOLOGY	9,524	2,472	0	663	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	15,941	10,337	16	624	0	90.00
91.00	09100	EMERGENCY	85,886	51,555	4,197	6,788	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)	659,548	365,883	20,109	33,804	38,180	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	80	2,422	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	338	10,230	0	0	0	192.00
194.00	07950	MARKETING	4,719	5,250	0	39	0	194.00
194.01	07951	FOUNDATION	83	2,222	0	59	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	162	4,900	0	0	0	194.03
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)	664,930	390,907	20,109	33,902	38,180	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
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	30,533					11.00
13.00	01300	NURSING ADMINISTRATION	824	36,067				13.00
15.00	01500	PHARMACY	0	0	184,894			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	898	0	0	35,605		16.00
17.00	01700	SOCIAL SERVICE	362	459	0	0	11,635	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,393	8,097	0	1,716	11,285	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,170	2,747	0	4,479	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,932	6,245	0	9,588	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	5,098	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,810	3,558	0	1,506	0	65.00
66.00	06600	PHYSICAL THERAPY	2,348	2,973	0	1,557	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	231	292	0	156	0	67.00
68.00	06800	SPEECH PATHOLOGY	96	7	0	116	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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,268	1,605	184,894	0	0	73.00
76.00	03610	SLEEP LAB	206	261	0	189	0	76.00
76.01	03480	ONCOLOGY	765	969	0	715	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,583	2,004	0	754	0	90.00
91.00	09100	EMERGENCY	5,409	6,850	0	9,731	350	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,295	36,067	184,894	35,605	11,635	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	238	0	0	0	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	0	0	0	0	194.03
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)	30,533	36,067	184,894	35,605	11,635	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	278,554	0	278,554	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	231,671	0	231,671	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,699	0	239,699	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	77,394	0	77,394	60.00
65.00	06500	RESPIRATORY THERAPY	70,898	0	70,898	65.00
66.00	06600	PHYSICAL THERAPY	110,511	0	110,511	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,322	0	6,322	67.00
68.00	06800	SPEECH PATHOLOGY	2,090	0	2,090	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	3,977	0	3,977	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,526	0	3,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	188,177	0	188,177	73.00
76.00	03610	SLEEP LAB	17,865	0	17,865	76.00
76.01	03480	ONCOLOGY	17,363	0	17,363	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	40,379	0	40,379	90.00
91.00	09100	EMERGENCY	238,692	0	238,692	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)	1,527,118	0	1,527,118	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,596	0	4,596	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,413	0	19,413	192.00
194.00	07950	MARKETING	14,548	0	14,548	194.00
194.01	07951	FOUNDATION	4,523	0	4,523	194.01
194.02	07952	CLINIC	0	0	0	194.02
194.03	07953	VACANT	9,299	0	9,299	194.03
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,579,497	0	1,579,497	202.00

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		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DIRECT COST)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	116,942					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		958,578				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	837	0	7,416,323			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	43,242	37,926	1,723,727	-4,703,998	17,386,382	5.00
7.00	00700	OPERATION OF PLANT	18,141	401,654	145,180	0	2,035,067	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,393	0	0	0	40,644	8.00
9.00	00900	HOUSEKEEPING	849	0	0	0	489,063	9.00
10.00	01000	DIETARY	2,310	4,684	0	0	132,303	10.00
11.00	01100	CAFETERIA	1,465	0	0	0	287,850	11.00
13.00	01300	NURSING ADMINISTRATION	1,688	1,194	205,930	0	310,669	13.00
15.00	01500	PHARMACY	1,299	31,778	356,408	0	3,959,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,035	0	79,975	0	188,110	16.00
17.00	01700	SOCIAL SERVICE	401	0	80,610	0	141,610	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,960	74,053	978,518	0	1,506,251	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,815	156,664	382,800	0	844,959	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,017	175,855	991,404	0	1,527,054	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,197	2,295	0	0	1,056,928	60.00
65.00	06500	RESPIRATORY THERAPY	1,714	19,451	495,763	0	752,319	65.00
66.00	06600	PHYSICAL THERAPY	5,154	811	437,833	0	654,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	182	0	59,577	0	83,061	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	19,087	0	48,571	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	103,991	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	92,202	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	730	6,900	49,716	0	79,375	76.00
76.01	03480	ONCOLOGY	346	0	169,096	0	249,033	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,447	0	262,529	0	416,821	90.00
91.00	09100	EMERGENCY	7,217	45,313	978,170	0	2,245,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	113,439	958,578	7,416,323	-4,703,998	17,245,625	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	0	2,094	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,432	0	0	0	8,845	192.00
194.00	07950	MARKETING	735	0	0	0	123,400	194.00
194.01	07951	FOUNDATION	311	0	0	0	2,181	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	686	0	0	0	4,237	194.03
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)	722,289	479,533	2,755,754		4,703,998	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.176472	0.500255	0.371580		0.270556	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,170		664,930	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000697		0.038244	205.00

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		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	54,722					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,393	130,988				8.00
9.00	00900	HOUSEKEEPING	849	25,332	1,738			9.00
10.00	01000	DIETARY	2,310	43	0	1,535		10.00
11.00	01100	CAFETERIA	1,465	67	0	0	196,017	11.00
13.00	01300	NURSING ADMINISTRATION	1,688	0	7	0	5,288	13.00
15.00	01500	PHARMACY	1,299	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,035	0	18	0	5,763	16.00
17.00	01700	SOCIAL SERVICE	401	0	0	0	2,326	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,960	40,262	274	1,535	41,054	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,815	12,887	269	0	13,928	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,017	13,541	152	0	31,662	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,197	0	75	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,714	0	69	0	18,039	65.00
66.00	06600	PHYSICAL THERAPY	5,154	10,356	393	0	15,073	66.00
67.00	06700	OCCUPATIONAL THERAPY	182	0	0	0	1,481	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	616	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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	21	0	8,139	73.00
76.00	03610	SLEEP LAB	730	1,056	41	0	1,321	76.00
76.01	03480	ONCOLOGY	346	0	34	0	4,911	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,447	107	32	0	10,160	90.00
91.00	09100	EMERGENCY	7,217	27,337	348	0	34,725	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,219	130,988	1,733	1,535	194,486	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,432	0	0	0	0	192.00
194.00	07950	MARKETING	735	0	2	0	0	194.00
194.01	07951	FOUNDATION	311	0	3	0	1,531	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	686	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,585,667	117,461	684,214	277,287	435,013	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.250959	0.896731	393.678941	180.642997	2.219262	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	390,907	20,109	33,902	38,180	30,533	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.143507	0.153518	19.506329	24.872964	0.155767	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/17/2016 9:21 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			13.00	15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
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	182,845					13.00
15.00	01500	PHARMACY	0	1,000				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	54,957,260			16.00
17.00	01700	SOCIAL SERVICE	2,326	0	0	4,990		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,047	0	2,648,522	4,840		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,928	0	6,912,615	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,662	0	14,796,374	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	0	7,867,364	0		60.00
65.00	06500	RESPIRATORY THERAPY	18,039	0	2,324,782	0		65.00
66.00	06600	PHYSICAL THERAPY	15,073	0	2,402,084	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,481	0	240,149	0		67.00
68.00	06800	SPEECH PATHOLOGY	33	0	179,244	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,139	1,000	0	0		73.00
76.00	03610	SLEEP LAB	1,321	0	291,307	0		76.00
76.01	03480	ONCOLOGY	4,911	0	1,103,127	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,160	0	1,163,239	0		90.00
91.00	09100	EMERGENCY	34,725	0	15,028,453	150		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	182,845	1,000	54,957,260	4,990		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	CLINIC	0	0	0	0		194.02
194.03	07953	VACANT	0	0	0	0		194.03
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)	488,973	5,092,669	355,036	210,253		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.674249	5,092.669000	0.006460	42.134870		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,067	184,894	35,605	11,635		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.197255	184.894000	0.000648	2.331663		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 9:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,133,072		3,133,072	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,673,102		1,673,102	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,499,771		2,499,771	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,527,045		1,527,045	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,167,307	0	1,167,307	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,327,879	0	1,327,879	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,933	0	122,933	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	64,325	0	64,325	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	132,126		132,126	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	117,148		117,148	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,140,765		5,140,765	0	0	73.00
76.00	03610	SLEEP LAB	160,778		160,778	0	0	76.00
76.01	03480	ONCOLOGY	377,302		377,302	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	667,893		667,893	0	0	90.00
91.00	09100	EMERGENCY	3,629,209		3,629,209	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	703,648		703,648		0	92.00
200.00		Subtotal (see instructions)	22,444,303	0	22,444,303	0	0	200.00
201.00		Less Observation Beds	703,648		703,648		0	201.00
202.00		Total (see instructions)	21,740,655	0	21,740,655	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/17/2016 9:21 am

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	2,095,678		2,095,678			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,004,060	5,908,555	6,912,615	0.242036	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	766,009	14,030,365	14,796,374	0.168945	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	745,073	7,122,291	7,867,364	0.194099	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	937,829	1,386,953	2,324,782	0.502115	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	112,380	2,289,704	2,402,084	0.552803	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,991	205,158	240,149	0.511903	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	29,574	149,670	179,244	0.358868	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	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	527,240	1,078,926	1,606,166	0.082262	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	135,456	127,786	263,242	0.445020	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,296,142	10,803,777	12,099,919	0.424859	0.000000	73.00
76.00	03610	SLEEP LAB	3,675	287,632	291,307	0.551919	0.000000	76.00
76.01	03480	ONCOLOGY	5,685	1,097,442	1,103,127	0.342030	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,753	1,150,486	1,163,239	0.574167	0.000000	90.00
91.00	09100	EMERGENCY	332,848	14,695,605	15,028,453	0.241489	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	552,844	552,844	1.272779	0.000000	92.00
200.00		Subtotal (see instructions)	8,039,393	60,887,194	68,926,587			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,039,393	60,887,194	68,926,587			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 9:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03610	SLEEP LAB	0.000000	76.00
76.01	03480	ONCOLOGY	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/17/2016 9:21 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,133,072		3,133,072	0	3,133,072	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,673,102		1,673,102	0	1,673,102	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,499,771		2,499,771	0	2,499,771	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,527,045		1,527,045	0	1,527,045	60.00
65.00	06500	RESPIRATORY THERAPY	1,167,307	0	1,167,307	0	1,167,307	65.00
66.00	06600	PHYSICAL THERAPY	1,327,879	0	1,327,879	0	1,327,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,933	0	122,933	0	122,933	67.00
68.00	06800	SPEECH PATHOLOGY	64,325	0	64,325	0	64,325	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	132,126		132,126	0	132,126	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	117,148		117,148	0	117,148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,140,765		5,140,765	0	5,140,765	73.00
76.00	03610	SLEEP LAB	160,778		160,778	0	160,778	76.00
76.01	03480	ONCOLOGY	377,302		377,302	0	377,302	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	667,893		667,893	0	667,893	90.00
91.00	09100	EMERGENCY	3,629,209		3,629,209	0	3,629,209	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	703,648		703,648		703,648	92.00
200.00		Subtotal (see instructions)	22,444,303	0	22,444,303	0	22,444,303	200.00
201.00		Less Observation Beds	703,648		703,648		703,648	201.00
202.00		Total (see instructions)	21,740,655	0	21,740,655	0	21,740,655	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 9:21 am

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	2,095,678		2,095,678			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,004,060	5,908,555	6,912,615	0.242036	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	766,009	14,030,365	14,796,374	0.168945	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	745,073	7,122,291	7,867,364	0.194099	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	937,829	1,386,953	2,324,782	0.502115	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	112,380	2,289,704	2,402,084	0.552803	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,991	205,158	240,149	0.511903	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	29,574	149,670	179,244	0.358868	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	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	527,240	1,078,926	1,606,166	0.082262	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	135,456	127,786	263,242	0.445020	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,296,142	10,803,777	12,099,919	0.424859	0.000000	73.00
76.00	03610	SLEEP LAB	3,675	287,632	291,307	0.551919	0.000000	76.00
76.01	03480	ONCOLOGY	5,685	1,097,442	1,103,127	0.342030	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,753	1,150,486	1,163,239	0.574167	0.000000	90.00
91.00	09100	EMERGENCY	332,848	14,695,605	15,028,453	0.241489	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	552,844	552,844	1.272779	0.000000	92.00
200.00		Subtotal (see instructions)	8,039,393	60,887,194	68,926,587			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,039,393	60,887,194	68,926,587			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 9:21 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03610	SLEEP LAB	0.000000	76.00
76.01	03480	ONCOLOGY	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II | Date/Time Prepared: 11/17/2016 9:21 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,673,102	231,671	1,441,431	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,499,771	239,699	2,260,072	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,527,045	77,394	1,449,651	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,167,307	70,898	1,096,409	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,327,879	110,511	1,217,368	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,933	6,322	116,611	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	64,325	2,090	62,235	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	132,126	3,977	128,149	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	117,148	3,526	113,622	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,140,765	188,177	4,952,588	0	0	73.00
76.00	03610	SLEEP LAB	160,778	17,865	142,913	0	0	76.00
76.01	03480	ONCOLOGY	377,302	17,363	359,939	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	667,893	40,379	627,514	0	0	90.00
91.00	09100	EMERGENCY	3,629,209	238,692	3,390,517	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	703,648	62,560	641,088	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	19,311,231	1,311,124	18,000,107	0	0	200.00
201.00		Less Observation Beds	703,648	62,560	641,088	0	0	201.00
202.00		Total (line 200 minus line 201)	18,607,583	1,248,564	17,359,019	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part II Date/Time Prepared: 11/17/2016 9:21 am
	Title XIX	Hospital	Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,673,102	6,912,615	0.242036	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,499,771	14,796,374	0.168945	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	58.00
60.00	06000	LABORATORY	1,527,045	7,867,364	0.194099	60.00
65.00	06500	RESPIRATORY THERAPY	1,167,307	2,324,782	0.502115	65.00
66.00	06600	PHYSICAL THERAPY	1,327,879	2,402,084	0.552803	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,933	240,149	0.511903	67.00
68.00	06800	SPEECH PATHOLOGY	64,325	179,244	0.358868	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	132,126	1,606,166	0.082262	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	117,148	263,242	0.445020	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,140,765	12,099,919	0.424859	73.00
76.00	03610	SLEEP LAB	160,778	291,307	0.551919	76.00
76.01	03480	ONCOLOGY	377,302	1,103,127	0.342030	76.01
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	667,893	1,163,239	0.574167	90.00
91.00	09100	EMERGENCY	3,629,209	15,028,453	0.241489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	703,648	552,844	1.272779	92.00
200.00		Subtotal (sum of lines 50 thru 199)	19,311,231	66,830,909		200.00
201.00		Less Observation Beds	703,648	0		201.00
202.00		Total (line 200 minus line 201)	18,607,583	66,830,909		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/17/2016 9:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	231,671	6,912,615	0.033514	366,338	12,277	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,699	14,796,374	0.016200	168,990	2,738	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	77,394	7,867,364	0.009837	324,718	3,194	60.00
65.00	06500	RESPIRATORY THERAPY	70,898	2,324,782	0.030497	578,061	17,629	65.00
66.00	06600	PHYSICAL THERAPY	110,511	2,402,084	0.046006	53,837	2,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,322	240,149	0.026325	12,393	326	67.00
68.00	06800	SPEECH PATHOLOGY	2,090	179,244	0.011660	9,100	106	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,977	1,606,166	0.002476	232,157	575	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,526	263,242	0.013395	66,110	886	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	188,177	12,099,919	0.015552	513,677	7,989	73.00
76.00	03610	SLEEP LAB	17,865	291,307	0.061327	0	0	76.00
76.01	03480	ONCOLOGY	17,363	1,103,127	0.015740	615	10	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	40,379	1,163,239	0.034713	5,746	199	90.00
91.00	09100	EMERGENCY	238,692	15,028,453	0.015883	378	6	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,560	552,844	0.113160	0	0	92.00
200.00		Total (lines 50-199)	1,311,124	66,830,909		2,332,120	48,412	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/17/2016 9:21 am

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 9:21 am

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	6,912,615	0.000000	0.000000	366,338	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,796,374	0.000000	0.000000	168,990	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	7,867,364	0.000000	0.000000	324,718	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,324,782	0.000000	0.000000	578,061	65.00
66.00	06600	PHYSICAL THERAPY	0	2,402,084	0.000000	0.000000	53,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	240,149	0.000000	0.000000	12,393	67.00
68.00	06800	SPEECH PATHOLOGY	0	179,244	0.000000	0.000000	9,100	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,606,166	0.000000	0.000000	232,157	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	263,242	0.000000	0.000000	66,110	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,099,919	0.000000	0.000000	513,677	73.00
76.00	03610	SLEEP LAB	0	291,307	0.000000	0.000000	0	76.00
76.01	03480	ONCOLOGY	0	1,103,127	0.000000	0.000000	615	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,163,239	0.000000	0.000000	5,746	90.00
91.00	09100	EMERGENCY	0	15,028,453	0.000000	0.000000	378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	552,844	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	66,830,909			2,332,120	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 9:21 am

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	0	90.00
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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/17/2016 9:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.242036	0	1,689,135	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168945	0	4,001,754	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.194099	0	2,538,575	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.502115	0	1,229,320	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.552803	0	743,840	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.511903	0	64,630	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.358868	0	32,555	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	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	0.082262	0	384,826	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.445020	0	46,780	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.424859	0	4,392,220	9,401	0	73.00
76.00	03610	SLEEP LAB	0.551919	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.342030	0	265,957	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.574167	0	600,729	0	0	90.00
91.00	09100	EMERGENCY	0.241489	0	3,254,704	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.272779	0	221,970	0	0	92.00
200.00		Subtotal (see instructions)		0	19,466,995	9,401	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	19,466,995	9,401	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/17/2016 9:21 am

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	408,831	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	676,076	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	492,735	0	60.00
65.00	06500	RESPIRATORY THERAPY	617,260	0	65.00
66.00	06600	PHYSICAL THERAPY	411,197	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,084	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,683	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	31,657	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	20,818	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,866,074	3,994	73.00
76.00	03610	SLEEP LAB	0	0	76.00
76.01	03480	ONCOLOGY	90,965	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	344,919	0	90.00
91.00	09100	EMERGENCY	785,975	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	282,519	0	92.00
200.00		Subtotal (see instructions)	6,073,793	3,994	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	6,073,793	3,994	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151308 | Component CCN: 15Z308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/17/2016 9:21 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.242036	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168945	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.194099	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.502115	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.552803	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.511903	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.358868	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	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	0.082262	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.445020	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.424859	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0.551919	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.342030	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.574167	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.241489	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.272779	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: 151308 | Component CCN: 15Z308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/17/2016 9:21 am

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03610	SLEEP LAB	0	0	76.00
76.01	03480	ONCOLOGY	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part I Date/Time Prepared: 11/17/2016 9:21 am
	Title XIX	Hospital	Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	278,554	22,525	256,029	1,813	141.22	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
200.00	Total (lines 30-199)	278,554		256,029	1,813		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	9	1,271	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
200.00	Total (lines 30-199)	9	1,271	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/17/2016 9:21 am

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	231,671	6,912,615	0.033514	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,699	14,796,374	0.016200	11,639	189	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	77,394	7,867,364	0.009837	11,024	108	60.00
65.00	06500	RESPIRATORY THERAPY	70,898	2,324,782	0.030497	5,479	167	65.00
66.00	06600	PHYSICAL THERAPY	110,511	2,402,084	0.046006	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,322	240,149	0.026325	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,090	179,244	0.011660	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,977	1,606,166	0.002476	1,332	3	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,526	263,242	0.013395	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	188,177	12,099,919	0.015552	16,347	254	73.00
76.00	03610	SLEEP LAB	17,865	291,307	0.061327	0	0	76.00
76.01	03480	ONCOLOGY	17,363	1,103,127	0.015740	570	9	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	40,379	1,163,239	0.034713	0	0	90.00
91.00	09100	EMERGENCY	238,692	15,028,453	0.015883	15,302	243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,560	552,844	0.113160	0	0	92.00
200.00		Total (lines 50-199)	1,311,124	66,830,909		61,693	973	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/17/2016 9:21 am

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,813	0.00	9	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	31.00
200.00		Total (lines 30-199)	1,813		9	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/17/2016 9:21 am

Title XIX | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/17/2016 9:21 am

Title XIX | 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	6,912,615	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,796,374	0.000000	0.000000	11,639	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	7,867,364	0.000000	0.000000	11,024	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,324,782	0.000000	0.000000	5,479	65.00
66.00	06600	PHYSICAL THERAPY	0	2,402,084	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	240,149	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	179,244	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,606,166	0.000000	0.000000	1,332	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	263,242	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,099,919	0.000000	0.000000	16,347	73.00
76.00	03610	SLEEP LAB	0	291,307	0.000000	0.000000	0	76.00
76.01	03480	ONCOLOGY	0	1,103,127	0.000000	0.000000	570	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,163,239	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	15,028,453	0.000000	0.000000	15,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	552,844	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	66,830,909			61,693	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/17/2016 9:21 am

Title XIX | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	0	90.00
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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/17/2016 9:21 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,978	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,813	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)	1,370	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	79	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)	80	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	3	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)	3	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	699	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)	74	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)	74	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)	3,133,072	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)	402	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)	402	25.00
26.00	Total swing-bed cost (see instructions)	253,355	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,879,717	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)	2,879,717	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)	1,588.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,110,271	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)	1,110,271	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 9:21 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	780,226	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,890,497	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)	117,539	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	117,539	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	235,078	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)	443	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,588.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	703,648	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/17/2016 9:21 am
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	278,554	3,133,072	0.088908	703,648	62,560	90.00
91.00	Nursing School cost	0	3,133,072	0.000000	703,648	0	91.00
92.00	Allied health cost	0	3,133,072	0.000000	703,648	0	92.00
93.00	All other Medical Education	0	3,133,072	0.000000	703,648	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/17/2016 9:21 am
	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)	1,978	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,813	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)	1,370	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	79	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)	80	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	3	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)	3	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	9	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)	3,133,072	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)	402	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)	402	25.00
26.00	Total swing-bed cost (see instructions)	253,355	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,879,717	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)	2,879,717	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)	1,588.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	14,295	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)	14,295	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/17/2016 9:21 am
	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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	17,802	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	32,097	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)	443	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,588.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	703,648	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/17/2016 9:21 am
	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	278,554	3,133,072	0.088908	703,648	62,560	90.00
91.00	Nursing School cost	0	3,133,072	0.000000	703,648	0	91.00
92.00	Allied health cost	0	3,133,072	0.000000	703,648	0	92.00
93.00	All other Medical Education	0	3,133,072	0.000000	703,648	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/17/2016 9:21 am

		Title XVIII	Hospital	Cost	
	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		881,139		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.242036	366,338	88,667	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168945	168,990	28,550	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.194099	324,718	63,027	60.00
65.00	06500 RESPIRATORY THERAPY	0.502115	578,061	290,253	65.00
66.00	06600 PHYSICAL THERAPY	0.552803	53,837	29,761	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.511903	12,393	6,344	67.00
68.00	06800 SPEECH PATHOLOGY	0.358868	9,100	3,266	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.082262	232,157	19,098	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.445020	66,110	29,420	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.424859	513,677	218,240	73.00
76.00	03610 SLEEP LAB	0.551919	0	0	76.00
76.01	03480 ONCOLOGY	0.342030	615	210	76.01
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.574167	5,746	3,299	90.00
91.00	09100 EMERGENCY	0.241489	378	91	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.272779	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,332,120	780,226	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)		2,332,120		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151308	Period: From 07/01/2015	Worksheet D-3
	Component CCN: 15Z308	To 06/30/2016	Date/Time Prepared: 11/17/2016 9:21 am
	Title XVIII	Swing Beds - SNF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.242036	43	10	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168945	8,730	1,475	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.194099	29,837	5,791	60.00
65.00	06500	RESPIRATORY THERAPY	0.502115	50,736	25,475	65.00
66.00	06600	PHYSICAL THERAPY	0.552803	20,577	11,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.511903	7,546	3,863	67.00
68.00	06800	SPEECH PATHOLOGY	0.358868	4,762	1,709	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.082262	24,682	2,030	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.445020	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.424859	94,727	40,246	73.00
76.00	03610	SLEEP LAB	0.551919	0	0	76.00
76.01	03480	ONCOLOGY	0.342030	792	271	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.574167	7,007	4,023	90.00
91.00	09100	EMERGENCY	0.241489	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.272779	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		249,439	96,268	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)		249,439		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 Date/Time Prepared: 11/17/2016 9:21 am

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		12,730		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.242036	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168945	11,639	1,966	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.194099	11,024	2,140	60.00
65.00	06500	RESPIRATORY THERAPY	0.502115	5,479	2,751	65.00
66.00	06600	PHYSICAL THERAPY	0.552803	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.511903	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.358868	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.082262	1,332	110	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.445020	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.424859	16,347	6,945	73.00
76.00	03610	SLEEP LAB	0.551919	0	0	76.00
76.01	03480	ONCOLOGY	0.342030	570	195	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.574167	0	0	90.00
91.00	09100	EMERGENCY	0.241489	15,302	3,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.272779	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		61,693	17,802	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)		61,693		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part B Date/Time Prepared: 11/17/2016 9:21 am

	Title XVIII	Hospital	Cost	
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		6,077,787	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)		6,077,787	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)		6,138,565	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)		43,886	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,408,085	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,686,594	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,686,594	30.00
31.00	Primary payer payments		1,251	31.00
32.00	Subtotal (line 30 minus line 31)		2,685,343	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,069,717	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		695,316	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		671,086	36.00
37.00	Subtotal (see instructions)		3,380,659	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)		3,380,659	40.00
40.01	Sequestration adjustment (see instructions)		67,613	40.01
41.00	Interim payments		3,220,862	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		92,184	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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2016 9:21 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,514,715		3,220,862	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)		1,514,715		3,220,862	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		190,906		92,184	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,705,621		3,313,046	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: 151308 | Component CCN: 15Z308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2016 9:21 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		276,590		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)		276,590		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		48,081		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		324,671		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/17/2016 9:21 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	397	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	699	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	252	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,370	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	68,926,587	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,829,757	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-2
Component CCN: 15Z308 | Date/Time Prepared: 11/17/2016 9:21 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	237,429	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)	97,231	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	148	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)	334,660	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	334,660	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)	334,660	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,610	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)	330,050	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)	1,919	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	1,247	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	926	0	18.00
19.00	Total (see instructions)	331,297	0	19.00
19.01	Sequestration adjustment (see instructions)	6,626	0	19.01
20.00	Interim payments	276,590	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)	48,081	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: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/17/2016 9:21 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,890,497	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)	1,890,497	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,902,974	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)	1,902,974	19.00
20.00	Deductibles (exclude professional component)	200,284	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,702,690	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,702,690	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	58,061	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	37,740	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,795	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,740,430	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)	1,740,430	30.00
30.01	Sequestration adjustment (see instructions)	34,809	30.01
31.00	Interim payments	1,514,715	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)	190,906	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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-3 Part VII Date/Time Prepared: 11/17/2016 9:21 am

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	32,097		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)	32,097	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)	32,097	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	61,693	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)	61,693	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)	61,693	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	29,596	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)	32,097	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)	32,097	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)	32,097	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)	32,097	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	32,097	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)	32,097	0	40.00
41.00	Interim payments	32,097	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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/17/2016 9:21 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	337,412	2,678	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,472,407	0	0	0	4.00
5.00	Other receivable	323,461	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,380,044	0	0	0	6.00
7.00	Inventory	461,810	0	0	0	7.00
8.00	Prepaid expenses	195,039	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,410,085	2,678	0	0	11.00
	FIXED ASSETS					
12.00	Land	457,300	0	0	0	12.00
13.00	Land improvements	528,489	0	0	0	13.00
14.00	Accumulated depreciation	-348,186	0	0	0	14.00
15.00	Buildings	13,449,742	0	0	0	15.00
16.00	Accumulated depreciation	-6,890,793	0	0	0	16.00
17.00	Leasehold improvements	6,349,093	0	0	0	17.00
18.00	Accumulated depreciation	-4,942,706	0	0	0	18.00
19.00	Fixed equipment	2,468,683	0	0	0	19.00
20.00	Accumulated depreciation	-2,070,601	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	5,451,545	0	0	0	23.00
24.00	Accumulated depreciation	-4,502,533	0	0	0	24.00
25.00	Minor equipment depreciable	76,140	0	0	0	25.00
26.00	Accumulated depreciation	-75,511	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)	9,950,662	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	15,556,576	29,806	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,556,576	29,806	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,917,323	32,484	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	577,631	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,282,520	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	89,293	0	0	0	43.00
44.00	Other current liabilities	1,337,406	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,286,850	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,131,953	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,131,953	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,418,803	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,498,520				52.00
53.00	Specific purpose fund		32,484			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)	15,498,520	32,484	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,917,323	32,484	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/17/2016 9:21 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,131,606		54,680		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,033,954				2.00
3.00	Total (sum of line 1 and line 2)		18,165,560		54,680		3.00
4.00	DEFERRED PENSION COST	0		0		0	4.00
5.00	DONATIONS	0		28,772		0	5.00
6.00	RELEASED OPERATING	57,114		0		0	6.00
7.00	OTHER	0		41,860		0	7.00
8.00	ROUNDING	0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		57,114		70,632		10.00
11.00	Subtotal (line 3 plus line 10)		18,222,674		125,312		11.00
12.00	TRANSFERS FROM AFFILIATES	1,800,109		0		0	12.00
13.00	DEFERRED PENSION COST	884,254		0		0	13.00
14.00	OTHER	39,789		0		0	14.00
15.00	RELEASED CAPITAL	0		57,114		0	15.00
16.00	RELEASED OPERATING	0		35,714		0	16.00
17.00	ROUNDING	2		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2,724,154		92,828		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,498,520		32,484		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	DEFERRED PENSION COST		0		4.00
5.00	DONATIONS		0		5.00
6.00	RELEASED OPERATING		0		6.00
7.00	OTHER		0		7.00
8.00	ROUNDING		0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	TRANSFERS FROM AFFILIATES		0		12.00
13.00	DEFERRED PENSION COST		0		13.00
14.00	OTHER		0		14.00
15.00	RELEASED CAPITAL		0		15.00
16.00	RELEASED OPERATING		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: 151308 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/17/2016 9:21 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,933,532		2,933,532	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)	2,933,532		2,933,532	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	2,933,532		2,933,532	17.00
18.00	Ancillary services	5,630,479	44,284,209	49,914,688	18.00
19.00	Outpatient services	363,275	16,372,855	16,736,130	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)	8,927,286	60,657,064	69,584,350	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,251,770		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)		22,251,770		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151308	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/17/2016 9:21 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	69,584,350	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,038,779	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,545,571	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,251,770	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,293,801	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-453,042	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	64,917	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	81,693	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	19,949	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	-9,078	24.00
24.01		0	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	35,714	24.02
24.03		0	24.03
24.04		0	24.04
25.00	Total other income (sum of lines 6-24)	-259,847	25.00
26.00	Total (line 5 plus line 25)	2,033,954	26.00
27.00	OTHER RECURRING	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,033,954	29.00