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: 151301	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/20/2016 3:06 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/20/2016 Time: 3:06 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT RANDOLPH HOSPITAL (151301) 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 Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	145,840	-124,362	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	44,477	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	190,317	-124,362	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: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 6:42 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 473 GREENVILLE AVE.	PO Box:			1.00
2.00	City: WINCHESTER	State: IN	Zip Code: 47934	County: RANDOLPH	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 RANDOLPH HOSPITAL	151301	34620	1	01/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT RANDOLPH SWING BEDS	15Z301	34620		09/01/1999	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	06/30/2016	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 6:42 pm

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
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: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/17/2016 6:42 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 6:42 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	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)	N	N	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.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/17/2016 6:42 pm

		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	N	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	60,100	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: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 6:42 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151301	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 6:42 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/17/2016 6:42 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/04/2016	Y	10/04/2016
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 6:42 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST VINCENT HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3232		JILL.HILL@STVINCENT.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151301	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 6:42 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2016 6:42 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	32,904.00	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	32,904.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	32,904.00	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: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/17/2016 6:42 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	562	47	1,371			1.00
2.00	HMO and other (see instructions)	86	343				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	163	0	200			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	725	47	1,571			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		58	430			13.00
14.00	Total (see instructions)	725	105	2,001	0.00	128.14	14.00
15.00	CAH visits	13,967	1,083	44,832			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	128.14	27.00
28.00	Observation Bed Days		0	416			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	8	112			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: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2016 6:42 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	170	25	539	1.00
2.00	HMO and other (see instructions)			27	136		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	170	25	539	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: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/17/2016 6:42 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.249295	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,310,391	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	22,653,072	6.00
7.00	Medicaid cost (line 1 times line 6)	5,647,298	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)	2,336,907	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)	2,336,907	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	4,161,210	1,594,360	5,755,570	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,037,369	397,466	1,434,835	21.00
22.00	Partial payment by patients approved for charity care	205,639	72,260	277,899	22.00
23.00	Cost of charity care (line 21 minus line 22)	831,730	325,206	1,156,936	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)	2,321,364	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	588,245	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,733,119	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	432,058	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,588,994	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,925,901	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,063,348	1,063,348	0	1,063,348	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		272,750	272,750	0	272,750	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	62,328	2,082,738	2,145,066	0	2,145,066	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,952,936	2,437,169	4,390,105	0	4,390,105	5.00
7.00	00700	OPERATION OF PLANT	65,434	1,504,137	1,569,571	0	1,569,571	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,133	68,133	0	68,133	8.00
9.00	00900	HOUSEKEEPING	0	405,991	405,991	0	405,991	9.00
10.00	01000	DIETARY	0	493,247	493,247	-304,363	188,884	10.00
11.00	01100	CAFETERIA	0	0	0	304,363	304,363	11.00
13.00	01300	NURSING ADMINISTRATION	633,083	51,947	685,030	0	685,030	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82,798	52,891	135,689	0	135,689	14.00
15.00	01500	PHARMACY	282,713	1,342,237	1,624,950	0	1,624,950	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	108,456	49,784	158,240	0	158,240	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,359,735	300,810	1,660,545	-695,359	965,186	30.00
43.00	04300	NURSERY	0	0	0	165,575	165,575	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	408,029	594,860	1,002,889	-70,183	932,706	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	507,844	507,844	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	634,365	93,273	727,638	0	727,638	54.00
57.00	05700	CT SCAN	18,716	15,130	33,846	0	33,846	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	38,257	212,389	250,646	0	250,646	58.00
60.00	06000	LABORATORY	0	1,422,081	1,422,081	0	1,422,081	60.00
65.00	06500	RESPIRATORY THERAPY	397,908	72,796	470,704	0	470,704	65.00
65.01	03950	SLEEP LAB	111,043	2,239	113,282	0	113,282	65.01
66.00	06600	PHYSICAL THERAPY	305,449	30,613	336,062	-2,351	333,711	66.00
67.00	06700	OCCUPATIONAL THERAPY	77,469	0	77,469	0	77,469	67.00
68.00	06800	SPEECH PATHOLOGY	7,901	0	7,901	0	7,901	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,503	21,503	118,722	140,225	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	187,150	187,150	0	187,150	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,008	35,291	211,299	0	211,299	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	823,116	949,986	1,773,102	-24,248	1,748,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,545,744	13,762,493	21,308,237	0	21,308,237	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	37,439	388	37,827	0	37,827	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	1,568	5,406	6,974	0	6,974	194.01
194.02	07952	OTHER NRCC - GRANTS	7,654	10,730	18,384	0	18,384	194.02
200.00		TOTAL (SUM OF LINES 118-199)	7,592,405	13,779,017	21,371,422	0	21,371,422	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-295,654	767,694		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	272,750		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	188,796	2,333,862		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	613,544	5,003,649		5.00
7.00	00700	OPERATION OF PLANT	-52,561	1,517,010		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,133		8.00
9.00	00900	HOUSEKEEPING	0	405,991		9.00
10.00	01000	DIETARY	0	188,884		10.00
11.00	01100	CAFETERIA	-75,575	228,788		11.00
13.00	01300	NURSING ADMINISTRATION	-1,458	683,572		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-516	135,173		14.00
15.00	01500	PHARMACY	-984	1,623,966		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,915	153,325		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-50,244	914,942		30.00
43.00	04300	NURSERY	0	165,575		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-179,863	752,843		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	507,844		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,973	724,665		54.00
57.00	05700	CT SCAN	0	33,846		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	250,646		58.00
60.00	06000	LABORATORY	0	1,422,081		60.00
65.00	06500	RESPIRATORY THERAPY	-149	470,555		65.00
65.01	03950	SLEEP LAB	0	113,282		65.01
66.00	06600	PHYSICAL THERAPY	-265	333,446		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	77,469		67.00
68.00	06800	SPEECH PATHOLOGY	0	7,901		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	140,225		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	187,150		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	211,299		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-382,990	1,365,864		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-245,807	21,062,430		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	37,827		192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	111,421	111,421		194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	6,974		194.01
194.02	07952	OTHER NRCC - GRANTS	0	18,384		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-134,386	21,237,036		200.00

RECLASSIFICATIONS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/17/2016 6:42 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	0	304,363	1.00
	TOTALS		0	304,363	
	C - NURSERY RECLASS				
1.00	NURSERY	43.00	135,349	32,551	1.00
	TOTALS		135,349	32,551	
	D - LDR RECLASS				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	415,136	99,840	1.00
	TOTALS		415,136	99,840	
	E - MEDICAL SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	118,722	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	118,722	
500.00	Grand Total: Increases		550,485	555,476	500.00

RECLASSIFICATIONS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/17/2016 6:42 pm

	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	304,363	0		1.00
	TOTALS		0	304,363			
	C - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	135,349	32,551	0		1.00
	TOTALS		135,349	32,551			
	D - LDR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	415,136	99,840	0		1.00
	TOTALS		415,136	99,840			
	E - MEDICAL SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	12,483	0		1.00
2.00	NURSERY	43.00	0	2,325	0		2.00
3.00	OPERATING ROOM	50.00	0	70,183	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,132	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	2,351	0		5.00
6.00	EMERGENCY	91.00	0	24,248	0		6.00
	TOTALS		0	118,722			
500.00	Grand Total: Decreases		550,485	555,476			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/17/2016 6:42 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	696,652	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,027,583	140,651	0	140,651	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	431,472	44,264	0	44,264	0	5.00
6.00	Movable Equipment	5,249,933	337,848	0	337,848	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,405,640	522,763	0	522,763	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,405,640	522,763	0	522,763	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	696,652	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	18,168,234	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	475,736	0	5.00
6.00	Movable Equipment	5,587,781	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,928,403	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,928,403	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/17/2016 6:42 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	609,837	0	436,740	16,523	248	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	272,435	0	0	315	0	2.00
3.00	Total (sum of lines 1-2)	882,272	0	436,740	16,838	248	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,063,348	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	272,750	2.00
3.00	Total (sum of lines 1-2)	0	1,336,098	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/17/2016 6:42 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	19,340,622	0	19,340,622	0.775847	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,587,781	0	5,587,781	0.224153	0	2.00
3.00	Total (sum of lines 1-2)	24,928,403	0	24,928,403	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	314,183	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	272,435	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	586,618	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	436,740	16,523	248	0	767,694	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	315	0	0	272,750	2.00
3.00	Total (sum of lines 1-2)	436,740	16,838	248	0	1,040,444	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/17/2016 6:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-153,924	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-2,788	CAP REL COSTS-BLDG & FIXT	1.00	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-614,136			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	1,061,517			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-75,575	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	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
33.00	PROVIDER ASSESSMENT TAX ADJUSTMENT	A	-328,425	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/17/2016 6:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	PROMOTIONAL ITEMS	A	-3,238	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER OPERATING INCOME	B	-38	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03			0		0.00	0	33.03
33.04	OTHER PHARMACY REVENUE	B	-984	PHARMACY	15.00	0	33.04
33.05	OTHER HIM REVENUE	B	-4,915	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06	OTHER OPERATING REVENUE	B	-186	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	CHARITABLE EXPENSE	A	-590	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	OTHER RADIOLOGY REVENUE	B	-25	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	OTHER PHYSICAL THERAPY REVENUE	B	-180	PHYSICAL THERAPY	66.00	0	33.09
33.10	DONATIONS	A	-5,695	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	AHA & IHA DUES	A	-952	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	LATE PENALTY FEES	A	-516	CENTRAL SERVICES & SUPPLY	14.00	0	33.12
33.13	PAVILION DEPRECIATION	A	-2,507	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	CARRYFORWARD ON HOSPITAL DEPR.	A	-104,668	CAP REL COSTS-BLDG & FIXT	1.00	9	33.14
33.15	MARKETING	A	-75	OPERATING ROOM	50.00	0	33.15
33.16	HOSPITALIST BENEFITS	A	-1,502	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	OTHER OPERATING REVENUE	B	-337	ADULTS & PEDIATRICS	30.00	0	33.17
33.18	ENTERTAINMENT	A	-23	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.19	ENTERTAINMENT	A	-9	RESPIRATORY THERAPY	65.00	0	33.19
33.20	ENTERTAINMENT	A	-85	PHYSICAL THERAPY	66.00	0	33.20
33.21	ENTERTAINMENT	A	-5,580	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	ENTERTAINMENT	A	-1,458	NURSING ADMINISTRATION	13.00	0	33.22
33.23	ENTERTAINMENT	A	-1,309	ADULTS & PEDIATRICS	30.00	0	33.23
33.24	ACCRUED INCENTIVES	A	347,987	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	ACCRUED INCENTIVES	A	-234,170	ADMINISTRATIVE & GENERAL	5.00	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-134,386				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: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/17/2016 6:42 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,406,981	1,214,749	2.00
3.00	194.00	OTHER NRCC - PUBLIC RELATION	HOME OFFICE	111,421	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST. VINCENT HLTH CHARGEBACK	348,926	348,926	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HLTH CHARGEBACK	1,347,390	1,347,390	4.01
4.02	9.00	HOUSEKEEPING	ST. VINCENT HLTH CHARGEBACK	-74,459	-74,459	4.02
4.03	13.00	NURSING ADMINISTRATION	ST. VINCENT HLTH CHARGEBACK	-26,489	-26,489	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HLTH CHARGEBACK	102,592	102,592	4.04
4.05	15.00	PHARMACY	ST. VINCENT HLTH CHARGEBACK	4,000	4,000	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HLTH CHARGEBACK	84,617	84,617	4.06
4.07	30.00	ADULTS & PEDIATRICS	ST. VINCENT HLTH CHARGEBACK	-13,310	-13,310	4.07
4.08	50.00	OPERATING ROOM	ST. VINCENT HLTH CHARGEBACK	1,313	1,313	4.08
4.10	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HLTH CHARGEBACK	69,703	69,703	4.10
4.11	194.01	OTHER NRCC - FOUNDATION	ST. VINCENT HLTH CHARGEBACK	-30,977	-30,977	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	568,013	951,302	4.12
4.13	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	397,770	428,972	4.13
4.14	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	7,204	7,769	4.14
4.15	7.00	OPERATION OF PLANT	TRIMEDX	921,089	973,650	4.15
4.16	50.00	OPERATING ROOM	TRIMEDX	2,081	2,200	4.16
4.17	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	321,757	96,157	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
5.00	0		0	6,549,622	5,488,105	5.00

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

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

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

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

6.00	G	ST. VINCENT HTH	100.00	ST. VINCENT HTH	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	B	ST. VINCENT HSP	100.00	ST. VINCENT HSP	100.00	8.00
9.00	A	TRIMEDX	0.00	TRIMEDX	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/17/2016 6:42 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	1,192,232	0		2.00
3.00	111,421	0		3.00
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
4.10	0	0		4.10
4.11	0	0		4.11
4.12	-383,289	0		4.12
4.13	-31,202	9		4.13
4.14	-565	9		4.14
4.15	-52,561	0		4.15
4.16	-119	0		4.16
4.17	225,600	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
5.00	1,061,517			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: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/17/2016 6:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	48,412	48,412	0	0	0	1.00
2.00	50.00	OPERATING ROOM	179,669	179,669	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	2,925	2,925	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	140	140	0	0	0	4.00
5.00	91.00	EMERGENCY	773,718	382,990	390,728	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,004,864	614,136	390,728		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	48,412		1.00
2.00	50.00	OPERATING ROOM	0	0	0	179,669		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,925		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	140		4.00
5.00	91.00	EMERGENCY	0	0	0	382,990		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	614,136		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	767,694	767,694				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	272,750		272,750			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,333,862	0	0	2,333,862		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,003,649	120,774	42,909	606,801	5,774,133	5.00
7.00	00700	OPERATION OF PLANT	1,517,010	45,871	16,297	20,331	1,599,509	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,133	6,262	2,225	0	76,620	8.00
9.00	00900	HOUSEKEEPING	405,991	5,871	2,086	0	413,948	9.00
10.00	01000	DIETARY	188,884	21,781	7,738	0	218,403	10.00
11.00	01100	CAFETERIA	228,788	5,127	1,822	0	235,737	11.00
13.00	01300	NURSING ADMINISTRATION	683,572	1,409	501	196,708	882,190	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	135,173	0	0	25,726	160,899	14.00
15.00	01500	PHARMACY	1,623,966	0	0	87,843	1,711,809	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	153,325	14,511	5,155	33,699	206,690	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	914,942	89,394	31,760	245,641	1,281,737	30.00
43.00	04300	NURSERY	165,575	1,223	435	42,055	209,288	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	752,843	75,587	26,855	126,780	982,065	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	507,844	22,984	8,166	128,989	667,983	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	724,665	60,891	21,634	197,106	1,004,296	54.00
57.00	05700	CT SCAN	33,846	0	0	5,815	39,661	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	250,646	0	0	11,887	262,533	58.00
60.00	06000	LABORATORY	1,422,081	17,055	6,059	0	1,445,195	60.00
65.00	06500	RESPIRATORY THERAPY	470,555	17,799	6,324	123,636	618,314	65.00
65.01	03950	SLEEP LAB	113,282	4,149	1,474	34,503	153,408	65.01
66.00	06600	PHYSICAL THERAPY	333,446	29,403	10,447	94,907	468,203	66.00
67.00	06700	OCCUPATIONAL THERAPY	77,469	3,102	1,102	24,071	105,744	67.00
68.00	06800	SPEECH PATHOLOGY	7,901	0	0	2,455	10,356	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,225	16,468	5,851	0	162,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187,150	0	0	0	187,150	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	211,299	11,321	4,022	54,688	281,330	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,365,864	41,576	14,771	255,723	1,677,934	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)	21,062,430	612,558	217,633	2,319,364	20,837,679	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,252	445	0	1,697	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,827	152,592	54,214	11,633	256,266	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	111,421	646	229	0	112,296	194.00
194.01	07951	OTHER NRCC - FOUNDATION	6,974	646	229	487	8,336	194.01
194.02	07952	OTHER NRCC - GRANTS	18,384	0	0	2,378	20,762	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,237,036	767,694	272,750	2,333,862	21,237,036	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 6:42 pm

		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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,774,133					5.00
7.00	00700	OPERATION OF PLANT	597,285	2,196,794				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,611	22,888	128,119			8.00
9.00	00900	HOUSEKEEPING	154,576	21,458	0	589,982		9.00
10.00	01000	DIETARY	81,556	79,608	0	21,820	401,387	10.00
11.00	01100	CAFETERIA	88,028	18,740	0	5,137	0	11.00
13.00	01300	NURSING ADMINISTRATION	329,426	5,150	0	1,412	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,083	0	0	0	0	14.00
15.00	01500	PHARMACY	639,225	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,182	53,036	0	14,537	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	478,624	326,728	39,366	89,555	401,387	30.00
43.00	04300	NURSERY	78,152	4,470	360	1,225	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	366,721	276,267	18,626	75,724	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	249,437	84,007	1,104	23,026	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	375,022	222,551	18,474	61,001	0	54.00
57.00	05700	CT SCAN	14,810	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	98,035	0	0	0	0	58.00
60.00	06000	LABORATORY	539,662	62,334	0	17,086	0	60.00
65.00	06500	RESPIRATORY THERAPY	230,890	65,052	0	17,831	0	65.00
65.01	03950	SLEEP LAB	57,285	15,163	0	4,156	0	65.01
66.00	06600	PHYSICAL THERAPY	174,835	107,467	0	29,456	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,487	11,337	0	3,107	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,867	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60,697	60,189	0	16,498	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,885	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,054	41,377	0	11,341	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	626,571	151,956	50,189	41,651	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)	5,625,006	1,629,778	128,119	434,563	401,387	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	634	4,578	0	1,255	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	95,694	557,718	0	152,870	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	41,933	2,360	0	647	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	3,113	2,360	0	647	0	194.01
194.02	07952	OTHER NRCC - GRANTS	7,753	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,774,133	2,196,794	128,119	589,982	401,387	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
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	347,642					11.00
13.00	01300	NURSING ADMINISTRATION	34,195	1,252,373				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,714	0	229,696			14.00
15.00	01500	PHARMACY	10,658	0	0	2,361,692		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,259	0	0	0	366,704	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,662	420,212	0	0	13,597	30.00
43.00	04300	NURSERY	7,752	56,495	0	0	2,951	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,593	157,360	0	0	44,231	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,779	173,293	0	0	9,050	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,506	0	0	0	37,031	54.00
57.00	05700	CT SCAN	731	0	0	0	47,446	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,812	0	0	0	11,468	58.00
60.00	06000	LABORATORY	0	0	0	0	86,895	60.00
65.00	06500	RESPIRATORY THERAPY	25,302	0	0	0	13,512	65.00
65.01	03950	SLEEP LAB	6,358	0	0	0	3,603	65.01
66.00	06600	PHYSICAL THERAPY	20,389	0	0	0	8,952	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,602	0	0	0	1,689	67.00
68.00	06800	SPEECH PATHOLOGY	477	0	0	0	115	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	98,386	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	131,310	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,553	0	0	2,361,692	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	57,175	416,667	0	0	86,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	343,517	1,224,027	229,696	2,361,692	366,704	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	3,890	28,346	0	0	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	230	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	5	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	347,642	1,252,373	229,696	2,361,692	366,704	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	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
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,108,868	0	3,108,868		30.00
43.00	04300	NURSERY	360,693	0	360,693		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,942,587	0	1,942,587		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,231,679	0	1,231,679		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,755,881	0	1,755,881		54.00
57.00	05700	CT SCAN	102,648	0	102,648		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	373,848	0	373,848		58.00
60.00	06000	LABORATORY	2,151,172	0	2,151,172		60.00
65.00	06500	RESPIRATORY THERAPY	970,901	0	970,901		65.00
65.01	03950	SLEEP LAB	239,973	0	239,973		65.01
66.00	06600	PHYSICAL THERAPY	809,302	0	809,302		66.00
67.00	06700	OCCUPATIONAL THERAPY	164,966	0	164,966		67.00
68.00	06800	SPEECH PATHOLOGY	14,815	0	14,815		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	398,314	0	398,314		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	388,345	0	388,345		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,811,347	0	2,811,347		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,108,307	0	3,108,307		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)	19,933,646	0	19,933,646		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,164	0	8,164		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,094,784	0	1,094,784		192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	157,236	0	157,236		194.00
194.01	07951	OTHER NRCC - FOUNDATION	14,686	0	14,686		194.01
194.02	07952	OTHER NRCC - GRANTS	28,520	0	28,520		194.02
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)	21,237,036	0	21,237,036		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	372,068	120,774	42,909	535,751	0	5.00
7.00	00700	OPERATION OF PLANT	0	45,871	16,297	62,168	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,262	2,225	8,487	0	8.00
9.00	00900	HOUSEKEEPING	0	5,871	2,086	7,957	0	9.00
10.00	01000	DIETARY	0	21,781	7,738	29,519	0	10.00
11.00	01100	CAFETERIA	0	5,127	1,822	6,949	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,409	501	1,910	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	55,767	0	0	55,767	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,388	14,511	5,155	22,054	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,571	89,394	31,760	157,725	0	30.00
43.00	04300	NURSERY	0	1,223	435	1,658	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,250	75,587	26,855	135,692	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	22,984	8,166	31,150	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	718	60,891	21,634	83,243	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	211,468	0	0	211,468	0	58.00
60.00	06000	LABORATORY	0	17,055	6,059	23,114	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,955	17,799	6,324	42,078	0	65.00
65.01	03950	SLEEP LAB	0	4,149	1,474	5,623	0	65.01
66.00	06600	PHYSICAL THERAPY	3,068	29,403	10,447	42,918	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,102	1,102	4,204	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,468	5,851	22,319	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318	11,321	4,022	15,661	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,245	41,576	14,771	59,592	0	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)	736,816	612,558	217,633	1,567,007	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,252	445	1,697	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	324	152,592	54,214	207,130	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	646	229	875	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	646	229	875	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	737,140	767,694	272,750	1,777,584	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 6:42 pm

		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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	535,751					5.00
7.00	00700	OPERATION OF PLANT	55,420	117,588				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,655	1,225	12,367			8.00
9.00	00900	HOUSEKEEPING	14,342	1,149	0	23,448		9.00
10.00	01000	DIETARY	7,567	4,261	0	867	42,214	10.00
11.00	01100	CAFETERIA	8,168	1,003	0	204	0	11.00
13.00	01300	NURSING ADMINISTRATION	30,566	276	0	56	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,575	0	0	0	0	14.00
15.00	01500	PHARMACY	59,304	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,161	2,839	0	578	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,410	17,489	3,800	3,559	42,214	30.00
43.00	04300	NURSERY	7,251	239	35	49	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,027	14,788	1,798	3,010	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,144	4,497	107	915	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,797	11,913	1,783	2,424	0	54.00
57.00	05700	CT SCAN	1,374	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,096	0	0	0	0	58.00
60.00	06000	LABORATORY	50,073	3,337	0	679	0	60.00
65.00	06500	RESPIRATORY THERAPY	21,423	3,482	0	709	0	65.00
65.01	03950	SLEEP LAB	5,315	812	0	165	0	65.01
66.00	06600	PHYSICAL THERAPY	16,222	5,752	0	1,171	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,664	607	0	123	0	67.00
68.00	06800	SPEECH PATHOLOGY	359	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,632	3,222	0	656	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,484	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,748	2,215	0	451	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	58,137	8,134	4,844	1,655	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)	521,914	87,240	12,367	17,271	42,214	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	59	245	0	50	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,879	29,851	0	6,075	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	3,891	126	0	26	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	289	126	0	26	0	194.01
194.02	07952	OTHER NRCC - GRANTS	719	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	535,751	117,588	12,367	23,448	42,214	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
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	16,324					11.00
13.00	01300	NURSING ADMINISTRATION	1,606	34,414				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	409	0	5,984			14.00
15.00	01500	PHARMACY	500	0	0	115,571		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	716	0	0	0	33,348	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,708	11,547	0	0	1,238	30.00
43.00	04300	NURSERY	364	1,552	0	0	269	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,014	4,324	0	0	4,026	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,117	4,762	0	0	824	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,761	0	0	0	3,370	54.00
57.00	05700	CT SCAN	34	0	0	0	4,318	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	85	0	0	0	1,044	58.00
60.00	06000	LABORATORY	0	0	0	0	7,879	60.00
65.00	06500	RESPIRATORY THERAPY	1,188	0	0	0	1,230	65.00
65.01	03950	SLEEP LAB	299	0	0	0	328	65.01
66.00	06600	PHYSICAL THERAPY	957	0	0	0	815	66.00
67.00	06700	OCCUPATIONAL THERAPY	169	0	0	0	154	67.00
68.00	06800	SPEECH PATHOLOGY	22	0	0	0	11	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,563	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,421	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	496	0	0	115,571	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,685	11,450	0	0	7,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,130	33,635	5,984	115,571	33,348	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	183	779	0	0	0	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	11	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,324	34,414	5,984	115,571	33,348	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	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
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	284,690	0	284,690		30.00
43.00	04300	NURSERY	11,417	0	11,417		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	198,679	0	198,679		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,516	0	66,516		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,291	0	139,291		54.00
57.00	05700	CT SCAN	5,726	0	5,726		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	221,693	0	221,693		58.00
60.00	06000	LABORATORY	85,082	0	85,082		60.00
65.00	06500	RESPIRATORY THERAPY	70,110	0	70,110		65.00
65.01	03950	SLEEP LAB	12,542	0	12,542		65.01
66.00	06600	PHYSICAL THERAPY	67,835	0	67,835		66.00
67.00	06700	OCCUPATIONAL THERAPY	8,921	0	8,921		67.00
68.00	06800	SPEECH PATHOLOGY	392	0	392		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,392	0	34,392		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,905	0	9,905		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	144,142	0	144,142		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	154,339	0	154,339		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)	1,515,672	0	1,515,672		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,051	0	2,051		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	252,897	0	252,897		192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	4,918	0	4,918		194.00
194.01	07951	OTHER NRCC - FOUNDATION	1,327	0	1,327		194.01
194.02	07952	OTHER NRCC - GRANTS	719	0	719		194.02
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)	1,777,584	0	1,777,584		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	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	CAP REL COSTS-BLDG & FIXT	78,458					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		78,458				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,511,297			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,343	12,343	1,952,936	-5,774,133	15,462,903	5.00
7.00	00700	OPERATION OF PLANT	4,688	4,688	65,434	0	1,599,509	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	640	640	0	0	76,620	8.00
9.00	00900	HOUSEKEEPING	600	600	0	0	413,948	9.00
10.00	01000	DIETARY	2,226	2,226	0	0	218,403	10.00
11.00	01100	CAFETERIA	524	524	0	0	235,737	11.00
13.00	01300	NURSING ADMINISTRATION	144	144	633,083	0	882,190	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	82,798	0	160,899	14.00
15.00	01500	PHARMACY	0	0	282,713	0	1,711,809	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483	1,483	108,456	0	206,690	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,136	9,136	790,570	0	1,281,737	30.00
43.00	04300	NURSERY	125	125	135,349	0	209,288	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,725	7,725	408,029	0	982,065	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,349	2,349	415,136	0	667,983	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,223	6,223	634,365	0	1,004,296	54.00
57.00	05700	CT SCAN	0	0	18,716	0	39,661	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	38,257	0	262,533	58.00
60.00	06000	LABORATORY	1,743	1,743	0	0	1,445,195	60.00
65.00	06500	RESPIRATORY THERAPY	1,819	1,819	397,908	0	618,314	65.00
65.01	03950	SLEEP LAB	424	424	111,043	0	153,408	65.01
66.00	06600	PHYSICAL THERAPY	3,005	3,005	305,449	0	468,203	66.00
67.00	06700	OCCUPATIONAL THERAPY	317	317	77,469	0	105,744	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	7,901	0	10,356	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	1,683	0	0	162,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	187,150	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,157	1,157	176,008	0	281,330	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,249	4,249	823,016	0	1,677,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,603	62,603	7,464,636	-5,774,133	15,063,546	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	128	0	0	1,697	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,595	15,595	37,439	0	256,266	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	66	66	0	0	112,296	194.00
194.01	07951	OTHER NRCC - FOUNDATION	66	66	1,568	0	8,336	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	7,654	0	20,762	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	767,694	272,750	2,333,862		5,774,133	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.784777	3.476382	0.310714		0.373418	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		535,751	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.034648	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	61,427					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	640	74,405				8.00
9.00	00900	HOUSEKEEPING	600	0	60,187			9.00
10.00	01000	DIETARY	2,226	0	2,226	100		10.00
11.00	01100	CAFETERIA	524	0	524	0	192,247	11.00
13.00	01300	NURSING ADMINISTRATION	144	0	144	0	18,910	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	4,819	14.00
15.00	01500	PHARMACY	0	0	0	0	5,894	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483	0	1,483	0	8,438	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,136	22,862	9,136	100	31,887	30.00
43.00	04300	NURSERY	125	209	125	0	4,287	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,725	10,817	7,725	0	11,941	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,349	641	2,349	0	13,150	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,223	10,729	6,223	0	20,741	54.00
57.00	05700	CT SCAN	0	0	0	0	404	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1,002	58.00
60.00	06000	LABORATORY	1,743	0	1,743	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,819	0	1,819	0	13,992	65.00
65.01	03950	SLEEP LAB	424	0	424	0	3,516	65.01
66.00	06600	PHYSICAL THERAPY	3,005	0	3,005	0	11,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	317	0	317	0	1,992	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	264	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	0	1,683	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,157	0	1,157	0	5,836	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,249	29,147	4,249	0	31,618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,572	74,405	44,332	100	189,966	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	0	128	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,595	0	15,595	0	2,151	192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	66	0	66	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	66	0	66	0	127	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0	3	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,196,794	128,119	589,982	401,387	347,642	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.762678	1.721914	9.802482	4,013.870000	1.808309	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	117,588	12,367	23,448	42,214	16,324	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.914272	0.166212	0.389586	422.140000	0.084912	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/17/2016 6:42 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
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	95,034					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	327,375				14.00
15.00	01500	PHARMACY	0	0	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	70,111,489		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,887	0	0	2,599,822		30.00
43.00	04300	NURSERY	4,287	0	0	564,163		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,941	0	0	8,457,138		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,150	0	0	1,730,370		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,080,499		54.00
57.00	05700	CT SCAN	0	0	0	9,071,866		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,192,785		58.00
60.00	06000	LABORATORY	0	0	0	16,610,610		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,583,565		65.00
65.01	03950	SLEEP LAB	0	0	0	688,899		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,711,758		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	322,997		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	22,073		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	140,225	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	187,150	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,000	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	31,618	0	0	16,474,944		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,883	327,375	10,000	70,111,489		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	2,151	0	0	0		192.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0		194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	0	0		194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,252,373	229,696	2,361,692	366,704		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.178157	0.701630	236.169200	0.005230		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	34,414	5,984	115,571	33,348		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.362123	0.018279	11.557100	0.000476		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,108,868		3,108,868	0	0	30.00
43.00	04300	NURSERY	360,693		360,693	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,942,587		1,942,587	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,231,679		1,231,679	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,755,881		1,755,881	0	0	54.00
57.00	05700	CT SCAN	102,648		102,648	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	373,848		373,848	0	0	58.00
60.00	06000	LABORATORY	2,151,172		2,151,172	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	970,901	0	970,901	0	0	65.00
65.01	03950	SLEEP LAB	239,973	0	239,973	0	0	65.01
66.00	06600	PHYSICAL THERAPY	809,302	0	809,302	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,966	0	164,966	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,815	0	14,815	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	398,314		398,314	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	388,345		388,345	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,811,347		2,811,347	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,108,307		3,108,307	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	650,874		650,874		0	92.00
200.00		Subtotal (see instructions)	20,584,520	0	20,584,520	0	0	200.00
201.00		Less Observation Beds	650,874		650,874		0	201.00
202.00		Total (see instructions)	19,933,646	0	19,933,646	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,121,895		2,121,895			30.00
43.00	04300	NURSERY	564,163		564,163			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,203,330	6,253,808	8,457,138	0.229698	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,356,490	373,880	1,730,370	0.711801	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	181,693	6,898,806	7,080,499	0.247988	0.000000	54.00
57.00	05700	CT SCAN	257,132	8,814,734	9,071,866	0.011315	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,702	2,186,083	2,192,785	0.170490	0.000000	58.00
60.00	06000	LABORATORY	966,243	15,644,367	16,610,610	0.129506	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	718,070	1,865,495	2,583,565	0.375799	0.000000	65.00
65.01	03950	SLEEP LAB	0	688,899	688,899	0.348343	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	122,022	1,589,736	1,711,758	0.472790	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,131	289,866	322,997	0.510735	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	4,192	17,881	22,073	0.671182	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	566,058	1,317,339	1,883,397	0.211487	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	476,165	283,487	759,652	0.511214	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,354,084	5,851,556	7,205,640	0.390159	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	248,004	16,226,940	16,474,944	0.188669	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	20,375	457,552	477,927	1.361869	0.000000	92.00
200.00		Subtotal (see instructions)	11,199,749	68,760,429	79,960,178			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,199,749	68,760,429	79,960,178			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
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
65.01	03950	SLEEP LAB	0.000000	65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 6:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,108,868		3,108,868	0	3,108,868	30.00
43.00	04300	NURSERY	360,693		360,693	0	360,693	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,942,587		1,942,587	0	1,942,587	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,231,679		1,231,679	0	1,231,679	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,755,881		1,755,881	0	1,755,881	54.00
57.00	05700	CT SCAN	102,648		102,648	0	102,648	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	373,848		373,848	0	373,848	58.00
60.00	06000	LABORATORY	2,151,172		2,151,172	0	2,151,172	60.00
65.00	06500	RESPIRATORY THERAPY	970,901	0	970,901	0	970,901	65.00
65.01	03950	SLEEP LAB	239,973	0	239,973	0	239,973	65.01
66.00	06600	PHYSICAL THERAPY	809,302	0	809,302	0	809,302	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,966	0	164,966	0	164,966	67.00
68.00	06800	SPEECH PATHOLOGY	14,815	0	14,815	0	14,815	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	398,314		398,314	0	398,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	388,345		388,345	0	388,345	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,811,347		2,811,347	0	2,811,347	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,108,307		3,108,307	0	3,108,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	650,874		650,874		650,874	92.00
200.00		Subtotal (see instructions)	20,584,520	0	20,584,520	0	20,584,520	200.00
201.00		Less Observation Beds	650,874		650,874		650,874	201.00
202.00		Total (see instructions)	19,933,646	0	19,933,646	0	19,933,646	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 6:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,121,895		2,121,895			30.00
43.00	04300	NURSERY	564,163		564,163			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,203,330	6,253,808	8,457,138	0.229698	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,356,490	373,880	1,730,370	0.711801	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	181,693	6,898,806	7,080,499	0.247988	0.000000	54.00
57.00	05700	CT SCAN	257,132	8,814,734	9,071,866	0.011315	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,702	2,186,083	2,192,785	0.170490	0.000000	58.00
60.00	06000	LABORATORY	966,243	15,644,367	16,610,610	0.129506	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	718,070	1,865,495	2,583,565	0.375799	0.000000	65.00
65.01	03950	SLEEP LAB	0	688,899	688,899	0.348343	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	122,022	1,589,736	1,711,758	0.472790	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,131	289,866	322,997	0.510735	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	4,192	17,881	22,073	0.671182	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	566,058	1,317,339	1,883,397	0.211487	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	476,165	283,487	759,652	0.511214	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,354,084	5,851,556	7,205,640	0.390159	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	248,004	16,226,940	16,474,944	0.188669	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	20,375	457,552	477,927	1.361869	0.000000	92.00
200.00		Subtotal (see instructions)	11,199,749	68,760,429	79,960,178			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,199,749	68,760,429	79,960,178			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 6:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
65.01	03950	SLEEP LAB	0.000000		65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II Date/Time Prepared: 11/17/2016 6:42 pm

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	1,942,587	198,679	1,743,908	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,231,679	66,516	1,165,163	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,755,881	139,291	1,616,590	0	0	54.00
57.00	05700	CT SCAN	102,648	5,726	96,922	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	373,848	221,693	152,155	0	0	58.00
60.00	06000	LABORATORY	2,151,172	85,082	2,066,090	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	970,901	70,110	900,791	0	0	65.00
65.01	03950	SLEEP LAB	239,973	12,542	227,431	0	0	65.01
66.00	06600	PHYSICAL THERAPY	809,302	67,835	741,467	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,966	8,921	156,045	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,815	392	14,423	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	398,314	34,392	363,922	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	388,345	9,905	378,440	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,811,347	144,142	2,667,205	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,108,307	154,339	2,953,968	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	650,874	59,603	591,271	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	17,114,959	1,279,168	15,835,791	0	0	200.00
201.00		Less Observation Beds	650,874	59,603	591,271	0	0	201.00
202.00		Total (line 200 minus line 201)	16,464,085	1,219,565	15,244,520	0	0	202.00

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

Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II Date/Time Prepared: 11/17/2016 6:42 pm

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	1,942,587	8,457,138	0.229698		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,231,679	1,730,370	0.711801		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,755,881	7,080,499	0.247988		54.00
57.00	05700	CT SCAN	102,648	9,071,866	0.011315		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	373,848	2,192,785	0.170490		58.00
60.00	06000	LABORATORY	2,151,172	16,610,610	0.129506		60.00
65.00	06500	RESPIRATORY THERAPY	970,901	2,583,565	0.375799		65.00
65.01	03950	SLEEP LAB	239,973	688,899	0.348343		65.01
66.00	06600	PHYSICAL THERAPY	809,302	1,711,758	0.472790		66.00
67.00	06700	OCCUPATIONAL THERAPY	164,966	322,997	0.510735		67.00
68.00	06800	SPEECH PATHOLOGY	14,815	22,073	0.671182		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	398,314	1,883,397	0.211487		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	388,345	759,652	0.511214		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,811,347	7,205,640	0.390159		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,108,307	16,474,944	0.188669		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	650,874	477,927	1.361869		92.00
200.00		Subtotal (sum of lines 50 thru 199)	17,114,959	77,274,120			200.00
201.00		Less Observation Beds	650,874	0			201.00
202.00		Total (line 200 minus line 201)	16,464,085	77,274,120			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	198,679	8,457,138	0.023492	407,195	9,566	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,516	1,730,370	0.038440	3,524	135	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,291	7,080,499	0.019672	37,550	739	54.00
57.00	05700	CT SCAN	5,726	9,071,866	0.000631	51,943	33	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	221,693	2,192,785	0.101101	2,879	291	58.00
60.00	06000	LABORATORY	85,082	16,610,610	0.005122	213,313	1,093	60.00
65.00	06500	RESPIRATORY THERAPY	70,110	2,583,565	0.027137	464,325	12,600	65.00
65.01	03950	SLEEP LAB	12,542	688,899	0.018206	0	0	65.01
66.00	06600	PHYSICAL THERAPY	67,835	1,711,758	0.039629	39,905	1,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,921	322,997	0.027619	14,563	402	67.00
68.00	06800	SPEECH PATHOLOGY	392	22,073	0.017759	2,828	50	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,392	1,883,397	0.018261	231,532	4,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,905	759,652	0.013039	158,483	2,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	144,142	7,205,640	0.020004	481,953	9,641	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	154,339	16,474,944	0.009368	8,949	84	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	59,603	477,927	0.124712	0	0	92.00
200.00		Total (lines 50-199)	1,279,168	77,274,120		2,118,942	42,509	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
65.01	03950	SLEEP LAB	0	0	0	0	0	65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,457,138	0.000000	0.000000	407,195	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,730,370	0.000000	0.000000	3,524	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,080,499	0.000000	0.000000	37,550	54.00
57.00	05700	CT SCAN	0	9,071,866	0.000000	0.000000	51,943	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,192,785	0.000000	0.000000	2,879	58.00
60.00	06000	LABORATORY	0	16,610,610	0.000000	0.000000	213,313	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,583,565	0.000000	0.000000	464,325	65.00
65.01	03950	SLEEP LAB	0	688,899	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	1,711,758	0.000000	0.000000	39,905	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	322,997	0.000000	0.000000	14,563	67.00
68.00	06800	SPEECH PATHOLOGY	0	22,073	0.000000	0.000000	2,828	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,883,397	0.000000	0.000000	231,532	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	759,652	0.000000	0.000000	158,483	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,205,640	0.000000	0.000000	481,953	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	16,474,944	0.000000	0.000000	8,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	477,927	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	77,274,120			2,118,942	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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
65.01	03950	SLEEP LAB	0	0	0		65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.229698	0	1,867,419	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.711801	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247988	0	1,746,096	0	0	54.00
57.00	05700	CT SCAN	0.011315	0	2,943,333	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.170490	0	632,055	0	0	58.00
60.00	06000	LABORATORY	0.129506	0	3,803,377	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.375799	0	813,550	0	0	65.00
65.01	03950	SLEEP LAB	0.348343	0	183,664	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.472790	0	524,178	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510735	0	77,575	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.671182	0	6,557	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.211487	0	467,584	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.511214	0	83,534	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.390159	0	2,009,443	3,006	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.188669	0	4,053,975	4,047	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.361869	0	196,701	0	0	92.00
200.00		Subtotal (see instructions)		0	19,409,041	7,053	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	19,409,041	7,053	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	428,942	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	433,011	0		54.00
57.00	05700	CT SCAN	33,304	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107,759	0		58.00
60.00	06000	LABORATORY	492,560	0		60.00
65.00	06500	RESPIRATORY THERAPY	305,731	0		65.00
65.01	03950	SLEEP LAB	63,978	0		65.01
66.00	06600	PHYSICAL THERAPY	247,826	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	39,620	0		67.00
68.00	06800	SPEECH PATHOLOGY	4,401	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	98,888	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,704	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	784,002	1,173		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	764,859	764		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	267,881	0		92.00
200.00		Subtotal (see instructions)	4,115,466	1,937		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,115,466	1,937		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151301 | Component CCN: 15Z301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.229698	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.711801	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247988	0	0	0	0	54.00
57.00	05700	CT SCAN	0.011315	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.170490	0	0	0	0	58.00
60.00	06000	LABORATORY	0.129506	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.375799	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0.348343	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.472790	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510735	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.671182	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.211487	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.511214	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.390159	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.188669	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.361869	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: 151301 | Component CCN: 15Z301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
65.01	03950	SLEEP LAB	0	0		65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/17/2016 6:42 pm

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	284,690	28,655	256,035	1,787	143.28	30.00
43.00	NURSERY	11,417		11,417	430	26.55	43.00
200.00	Total (lines 30-199)	296,107		267,452	2,217		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	47	6,734				30.00
43.00	NURSERY	58	1,540				43.00
200.00	Total (lines 30-199)	105	8,274				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/17/2016 6:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	198,679	8,457,138	0.023492	124,827	2,932	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,516	1,730,370	0.038440	144,350	5,549	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,291	7,080,499	0.019672	11,801	232	54.00
57.00	05700	CT SCAN	5,726	9,071,866	0.000631	23,932	15	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	221,693	2,192,785	0.101101	3,823	387	58.00
60.00	06000	LABORATORY	85,082	16,610,610	0.005122	87,737	449	60.00
65.00	06500	RESPIRATORY THERAPY	70,110	2,583,565	0.027137	19,626	533	65.00
65.01	03950	SLEEP LAB	12,542	688,899	0.018206	0	0	65.01
66.00	06600	PHYSICAL THERAPY	67,835	1,711,758	0.039629	802	32	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,921	322,997	0.027619	369	10	67.00
68.00	06800	SPEECH PATHOLOGY	392	22,073	0.017759	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,392	1,883,397	0.018261	31,721	579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,905	759,652	0.013039	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	144,142	7,205,640	0.020004	68,253	1,365	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	154,339	16,474,944	0.009368	28,225	264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	59,603	477,927	0.124712	2,916	364	92.00
200.00		Total (lines 50-199)	1,279,168	77,274,120		548,382	12,711	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/17/2016 6:42 pm

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
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,787	0.00	47	0		30.00
43.00	04300	NURSERY	430	0.00	58	0		43.00
200.00		Total (lines 30-199)	2,217		105	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 6:42 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
65.01	03950	SLEEP LAB	0	0	0	0	0	65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 6:42 pm

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	8,457,138	0.000000	0.000000	124,827	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,730,370	0.000000	0.000000	144,350	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,080,499	0.000000	0.000000	11,801	54.00
57.00	05700	CT SCAN	0	9,071,866	0.000000	0.000000	23,932	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,192,785	0.000000	0.000000	3,823	58.00
60.00	06000	LABORATORY	0	16,610,610	0.000000	0.000000	87,737	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,583,565	0.000000	0.000000	19,626	65.00
65.01	03950	SLEEP LAB	0	688,899	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	1,711,758	0.000000	0.000000	802	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	322,997	0.000000	0.000000	369	67.00
68.00	06800	SPEECH PATHOLOGY	0	22,073	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,883,397	0.000000	0.000000	31,721	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	759,652	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,205,640	0.000000	0.000000	68,253	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	16,474,944	0.000000	0.000000	28,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	477,927	0.000000	0.000000	2,916	92.00
200.00		Total (lines 50-199)	0	77,274,120			548,382	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/17/2016 6:42 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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
65.01	03950	SLEEP LAB	0	0	0		65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,987	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,787	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)	1,371	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	100	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)	100	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	562	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)	82	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)	81	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)	3,108,868	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	312,920	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,795,948	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)	2,795,948	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)	1,564.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	879,305	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)	879,305	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	656,463	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,535,768	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)	128,297	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	126,733	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	255,030	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)	416	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,564.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	650,874	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	284,690	3,108,868	0.091574	650,874	59,603	90.00
91.00	Nursing School cost	0	3,108,868	0.000000	650,874	0	91.00
92.00	Allied health cost	0	3,108,868	0.000000	650,874	0	92.00
93.00	All other Medical Education	0	3,108,868	0.000000	650,874	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151301	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/17/2016 6:42 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,987	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,787	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)	1,371	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	100	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)	100	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	47	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)	430	15.00
16.00	Nursery days (title V or XIX only)	58	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)	3,108,868	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	312,920	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,795,948	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)	2,795,948	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)	1,564.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	73,536	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)	73,536	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 6:42 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	360,693	430	838.82	58	48,652	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	197,210	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	319,398	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)	416	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,564.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	650,874	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 6:42 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	284,690	3,108,868	0.091574	650,874	59,603	90.00
91.00	Nursing School cost	0	3,108,868	0.000000	650,874	0	91.00
92.00	Allied health cost	0	3,108,868	0.000000	650,874	0	92.00
93.00	All other Medical Education	0	3,108,868	0.000000	650,874	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		724,022		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229698	407,195	93,532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.711801	3,524	2,508	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247988	37,550	9,312	54.00
57.00	05700	CT SCAN	0.011315	51,943	588	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.170490	2,879	491	58.00
60.00	06000	LABORATORY	0.129506	213,313	27,625	60.00
65.00	06500	RESPIRATORY THERAPY	0.375799	464,325	174,493	65.00
65.01	03950	SLEEP LAB	0.348343	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.472790	39,905	18,867	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510735	14,563	7,438	67.00
68.00	06800	SPEECH PATHOLOGY	0.671182	2,828	1,898	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.211487	231,532	48,966	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.511214	158,483	81,019	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.390159	481,953	188,038	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.188669	8,949	1,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.361869	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,118,942	656,463	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)		2,118,942		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151301 | Component CCN: 15Z301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229698	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.711801	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247988	362	90	54.00
57.00	05700	CT SCAN	0.011315	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.170490	0	0	58.00
60.00	06000	LABORATORY	0.129506	14,756	1,911	60.00
65.00	06500	RESPIRATORY THERAPY	0.375799	29,923	11,245	65.00
65.01	03950	SLEEP LAB	0.348343	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.472790	47,200	22,316	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510735	9,733	4,971	67.00
68.00	06800	SPEECH PATHOLOGY	0.671182	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.211487	12,554	2,655	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.511214	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.390159	60,242	23,504	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.188669	295	56	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.361869	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		175,065	66,748	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)		175,065		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/17/2016 6:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		88,295		30.00
43.00	04300	NURSERY		47,063		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229698	124,827	28,673	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.711801	144,350	102,748	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247988	11,801	2,927	54.00
57.00	05700	CT SCAN	0.011315	23,932	271	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.170490	3,823	652	58.00
60.00	06000	LABORATORY	0.129506	87,737	11,362	60.00
65.00	06500	RESPIRATORY THERAPY	0.375799	19,626	7,375	65.00
65.01	03950	SLEEP LAB	0.348343	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.472790	802	379	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510735	369	188	67.00
68.00	06800	SPEECH PATHOLOGY	0.671182	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.211487	31,721	6,709	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.511214	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.390159	68,253	26,630	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.188669	28,225	5,325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.361869	2,916	3,971	92.00
200.00		Total (sum of lines 50-94 and 96-98)		548,382	197,210	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)		548,382		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151301	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/17/2016 6:42 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,117,403	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,117,403	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,158,577	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)	40,998	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,085,090	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,032,489	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,032,489	30.00
31.00	Primary payer payments	126	31.00
32.00	Subtotal (line 30 minus line 31)	1,032,363	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)	873,696	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	567,902	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	483,112	36.00
37.00	Subtotal (see instructions)	1,600,265	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,600,265	40.00
40.01	Sequestration adjustment (see instructions)	32,005	40.01
41.00	Interim payments	1,692,622	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-124,362	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: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,123,080		1,692,622	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	01/13/2016	95,600		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)		95,600		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)		1,218,680		1,692,622	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		145,840		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		124,362	6.02
7.00	Total Medicare program liability (see instructions)		1,364,520		1,568,260	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: 151301 | Component CCN: 15Z301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2016 6:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		266,729		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)		266,729		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		44,477		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		311,206		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151301 Component CCN: 15Z301	Period: From 07/01/2015 To 06/30/2016	Worksheet E-2 Date/Time Prepared: 11/17/2016 6:42 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	257,580	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)	67,415	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	163	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)	324,995	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	324,995	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)	324,995	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,438	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)	317,557	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	317,557	0	19.00
19.01	Sequestration adjustment (see instructions)	6,351	0	19.01
20.00	Interim payments	266,729	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)	44,477	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: 151301	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/17/2016 6:42 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,535,768	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)	1,535,768	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,551,126	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)	1,551,126	19.00
20.00	Deductibles (exclude professional component)	175,924	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,375,202	22.00
23.00	Coinsurance	3,178	23.00
24.00	Subtotal (line 22 minus line 23)	1,372,024	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,297	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,343	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8,830	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,392,367	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,392,367	30.00
30.01	Sequestration adjustment (see instructions)	27,847	30.01
31.00	Interim payments	1,218,680	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)	145,840	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: 151301	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/17/2016 6:42 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	319,398		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)	319,398	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)	319,398	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	88,295		8.00
9.00	Ancillary service charges	548,382	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)	636,677	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)	636,677	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	317,279	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)	319,398	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)	319,398	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)	319,398	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)	319,398	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	319,398	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)	319,398	0	40.00
41.00	Interim payments	319,398	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: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/17/2016 6:42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,349	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,678,658	0	0	0	4.00
5.00	Other receivable	610,763	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,711,499	0	0	0	6.00
7.00	Inventory	364,152	0	0	0	7.00
8.00	Prepaid expenses	396	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)	3,948,819	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	696,652	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	18,168,234	0	0	0	15.00
16.00	Accumulated depreciation	-8,574,226	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	475,736	0	0	0	19.00
20.00	Accumulated depreciation	-431,841	0	0	0	20.00
21.00	Automobiles and trucks	12,322	0	0	0	21.00
22.00	Accumulated depreciation	-12,322	0	0	0	22.00
23.00	Major movable equipment	5,575,459	0	0	0	23.00
24.00	Accumulated depreciation	-4,839,631	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,070,383	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	30,978,125	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	343,842	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	31,321,967	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,341,169	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,123,141	0	0	0	37.00
38.00	Salaries, wages, and fees payable	828,069	0	0	0	38.00
39.00	Payroll taxes payable	63,133	0	0	0	39.00
40.00	Notes and loans payable (short term)	182,616	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,082,383	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,279,342	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,747,421	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	52,789	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,800,210	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,079,552	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,261,617				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	29,261,617	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,341,169	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/17/2016 6:42 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		31,067,304		56,039		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,520,249				2.00
3.00	Total (sum of line 1 and line 2)		33,587,553		56,039		3.00
4.00	DEFERRED PENSION COST	-395,954		0		0	4.00
5.00	DONATIONS	94,645		-94,645		0	5.00
6.00	OTHER	0		45,449		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-301,309		-49,196		10.00
11.00	Subtotal (line 3 plus line 10)		33,286,244		6,843		11.00
12.00	TRANSFERS TO AFFILIATES	3,952,526		0		0	12.00
13.00	OTHER PENSION RELATED ADJ	0		0		0	13.00
14.00	RELEASED OPERATING	0		6,843		0	14.00
15.00	RELEASED CAPITAL	72,101		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		4,024,627		6,843		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,261,617		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	DEFERRED PENSION COST		0			4.00
5.00	DONATIONS		0			5.00
6.00	OTHER		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFERS TO AFFILIATES		0			12.00
13.00	OTHER PENSION RELATED ADJ		0			13.00
14.00	RELEASED OPERATING		0			14.00
15.00	RELEASED CAPITAL		0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151301 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/17/2016 6:42 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,899,985		4,899,985	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)	4,899,985		4,899,985	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,899,985		4,899,985	17.00
18.00	Ancillary services	6,888,822	51,256,974	58,145,796	18.00
19.00	Outpatient services	248,004	16,666,393	16,914,397	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	SART GRANT	0	2,173	2,173	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,036,811	67,925,540	79,962,351	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,371,422		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,371,422		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151301	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/17/2016 6:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	79,962,351	1.00
2.00	Less contractual allowances and discounts on patients' accounts	55,406,395	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,555,956	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,371,422	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,184,534	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-2,000	6.00
7.00	Income from investments	156,712	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	75,575	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	0	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	138,945	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	6,665	24.00
24.01	ROUNDING	1	24.01
24.02	UNREALIZED GAINS/LOSSES	-1,070,005	24.02
24.03	GRANTS	22,979	24.03
24.04	NET ASSETS RELEASED FROM RESTRICTION	6,843	24.04
25.00	Total other income (sum of lines 6-24)	-664,285	25.00
26.00	Total (line 5 plus line 25)	2,520,249	26.00
27.00	LOSS ON INTEREST RATE SWAPS	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)	2,520,249	29.00