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: 151314	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/18/2016 1:36 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/18/2016 Time: 1:36 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 SALEM (151314) 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	-62,985	-560,109	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	-27,716	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-90,701	-560,109	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: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 12:01 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 911 N. SHELBY STREET	PO Box:			1.00
2.00	City: SALEM	State: IN	Zip Code: 47167	County: WASHINGTON	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 SALEM	151314	31140	1	12/01/2002	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 SALEM	15Z314	31140		12/01/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	06/30/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2016 12:01 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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2016 12:01 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: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 12:01 pm

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

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

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

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

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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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:	33,599	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: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 12:01 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 10330 N. MERIDIAN STREET	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: 151314	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 12:01 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: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/18/2016 12:01 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	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2016 12:01 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				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519		JILL.HILL@STVINCENT.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151314	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/18/2016 12:01 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.	MANAGER, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2016 12:01 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	10,392.00	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	10,392.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	10,392.00	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	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2016 12:01 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)	230	20	433			1.00
2.00	HMO and other (see instructions)	38	40				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	190	0	202			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	26			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	420	20	661			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)	420	20	661	0.00	109.69	14.00
15.00	CAH visits	10,407	633	32,220			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	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	109.69	27.00
28.00	Observation Bed Days		0	516			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2016 12:01 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	75	2	132	1.00
2.00	HMO and other (see instructions)			17	11		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	75	2	132	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	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/18/2016 12:01 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)	0.285224	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	925,581	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	13,201,167	6.00
7.00	Medicaid cost (line 1 times line 6)	3,765,290	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)	2,839,709	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)	2,839,709	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,694,357	789,895	2,484,252	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	483,271	225,297	708,568	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	483,271	225,297	708,568	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)	1,477,395	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	619,099	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	858,296	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	244,807	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	953,375	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,793,084	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/18/2016 12:01 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		11,188	11,188	0	11,188	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	47,890	1,916,972	1,964,862	0	1,964,862	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,606,329	1,916,343	3,522,672	0	3,522,672	5.00
7.00	00700	OPERATION OF PLANT	0	1,332,025	1,332,025	0	1,332,025	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,872	50,872	0	50,872	8.00
9.00	00900	HOUSEKEEPING	0	307,165	307,165	0	307,165	9.00
10.00	01000	DIETARY	0	352,577	352,577	-304,343	48,234	10.00
11.00	01100	CAFETERIA	0	0	0	304,343	304,343	11.00
13.00	01300	NURSING ADMINISTRATION	20,582	12,216	32,798	0	32,798	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	107,027	25,968	132,995	0	132,995	14.00
15.00	01500	PHARMACY	168,861	170,084	338,945	0	338,945	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	189,817	33,047	222,864	0	222,864	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	809,951	112,172	922,123	-16,641	905,482	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	537,856	468,800	1,006,656	-114,184	892,472	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	613,643	502,201	1,115,844	0	1,115,844	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	60,428	155,177	215,605	0	215,605	58.00
60.00	06000	LABORATORY	0	1,173,108	1,173,108	0	1,173,108	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0	0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	245,450	16,426	261,876	0	261,876	65.00
66.00	06600	PHYSICAL THERAPY	431,408	13,133	444,541	-5,615	438,926	66.00
67.00	06700	OCCUPATIONAL THERAPY	60,192	443	60,635	3,317	63,952	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	118,681	9,337	128,018	0	128,018	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,601	9,601	158,512	168,113	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	68,704	68,704	0	68,704	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	274,225	274,225	0	274,225	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	134,529	64,393	198,922	0	198,922	75.01
75.03	07501	ADULT MENTAL HEALTH	0	411,582	411,582	0	411,582	75.03
76.97	07697	CARDIAC REHABILITATION	78,415	8,929	87,344	0	87,344	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	753,184	1,002,466	1,755,650	-25,389	1,730,261	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,984,243	10,419,154	16,403,397	0	16,403,397	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,766	2,209	118,975	0	118,975	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	59,199	6,149	65,348	0	65,348	193.01
193.02	19302	NEW HORIZON OP	7,248	76	7,324	0	7,324	193.02
200.00		TOTAL (SUM OF LINES 118-199)	6,167,456	10,427,588	16,595,044	0	16,595,044	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/18/2016 12:01 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	0	11,188		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAP RELATED COST	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	86,068	2,050,930		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-35,458	3,487,214		5.00
7.00	00700	OPERATION OF PLANT	-49,092	1,282,933		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,872		8.00
9.00	00900	HOUSEKEEPING	0	307,165		9.00
10.00	01000	DIETARY	0	48,234		10.00
11.00	01100	CAFETERIA	-69,954	234,389		11.00
13.00	01300	NURSING ADMINISTRATION	0	32,798		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	132,995		14.00
15.00	01500	PHARMACY	0	338,945		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,859	216,005		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-143,100	762,382		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	892,472		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-165,704	950,140		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	215,605		58.00
60.00	06000	LABORATORY	0	1,173,108		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
65.00	06500	RESPIRATORY THERAPY	0	261,876		65.00
66.00	06600	PHYSICAL THERAPY	0	438,926		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	63,952		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	-29,119	98,899		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	168,113		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	68,704		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	274,225		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03950	SLEEP DISORDER	-53,659	145,263		75.01
75.03	07501	ADULT MENTAL HEALTH	0	411,582		75.03
76.97	07697	CARDIAC REHABILITATION	0	87,344		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-150,000	1,580,261		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-616,877	15,786,520		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	118,975		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	51,112	116,460		193.01
193.02	19302	NEW HORIZON OP	0	7,324		193.02
200.00		TOTAL (SUM OF LINES 118-199)	-565,765	16,029,279		200.00

RECLASSIFICATIONS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/18/2016 12:01 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	304,343		1.00
	TOTALS		0	304,343		
	B - BILLABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	158,512		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
	TOTALS		0	158,512		
	C - PT / OT					
1.00	OCCUPATIONAL THERAPY	67.00	2,041	1,276		1.00
	TOTALS		2,041	1,276		
500.00	Grand Total: Increases		2,041	464,131		500.00

RECLASSIFICATIONS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/18/2016 12:01 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	304,343	0		1.00
	TOTALS		0	304,343			
	B - BILLABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	16,641	0		1.00
2.00	OPERATING ROOM	50.00	0	114,184	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	2,298	0		3.00
4.00	EMERGENCY	91.00	0	25,389	0		4.00
	TOTALS		0	158,512			
	C - PT / OT						
1.00	PHYSICAL THERAPY	66.00	2,041	1,276	0		1.00
	TOTALS		2,041	1,276			
500.00	Grand Total: Decreases		2,041	464,131			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/18/2016 12:01 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	180,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,002,111	185,639	0	185,639	0	3.00
4.00	Building Improvements	856,968	2,111	0	2,111	0	4.00
5.00	Fixed Equipment	538,421	81,595	0	81,595	0	5.00
6.00	Movable Equipment	1,321,290	447,577	0	447,577	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	3,898,790	716,922	0	716,922	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	3,898,790	716,922	0	716,922	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	180,000	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	1,187,750	0	3.00
4.00	Building Improvements	859,079	0	4.00
5.00	Fixed Equipment	620,016	0	5.00
6.00	Movable Equipment	1,768,867	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4,615,712	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	4,615,712	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/18/2016 12:01 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	0	0	0	11,188	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	11,188	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	11,188		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	11,188		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/18/2016 12:01 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	4,764,906	0	4,764,906	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	4,764,906	0	4,764,906	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	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	11,188	0	0	11,188	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	11,188	0	0	11,188	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/18/2016 12:01 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-511,104			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	206,979			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-69,954	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	B	-22,088	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
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	OTHER REVENUE - ADMINISTRATION	B	-9,994	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/18/2016 12:01 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	
33.02	ASSOCIATION DUES LOBBYING EXPENSE	A	-847	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PROVIDER TAX	A	-142,631	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	CABLE TV	A	-3,471	OPERATION OF PLANT	7.00	0	33.04
33.05	BIOTERRORISM GRANT	B	-15,039	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MEDICAL RECORDS FOR SPN	A	15,229	MEDICAL RECORDS & LIBRARY	16.00	0	33.06
33.07	PROFESSIONAL COMP BENEFITS	A	-14,553	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	BUILDING RENTAL INCOME	B	-29,119	ELECTROCARDIOLOGY	69.00	0	33.08
33.09	BUILDING RENTAL INCOME	B	-1,359	SLEEP DISORDER	75.01	0	33.09
33.10	BUILDING RENTAL INCOME	B	-54,133	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PAYROLL INCENTIVE	A	285,282	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PAYROLL INCENTIVE	A	-198,373	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	CHARITABLE EXPENSE	A	-590	ADMINISTRATIVE & GENERAL	5.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-565,765				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: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2016 12:01 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	1,515,858	1,129,709	2.00
3.00	193.01	MARKETING/ PUBLIC RELATIONS	HOME OFFICE	51,112	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	311,957	311,957	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	1,150,178	1,150,178	4.01
4.02	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	1,274	1,274	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	SVH CHARGEBACKS	120,726	120,726	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACKS	58,380	58,380	4.04
4.05	54.00	RADIOLOGY - DIAGNOSTIC	SVH CHARGEBACKS	16,540	16,540	4.05
4.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF INSURANCE	608,671	817,341	4.06
4.07	7.00	OPERATION OF PLANT	ASCENSION - TRIMEDX	799,469	845,090	4.07
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION - PENSION	225,688	201,679	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
5.00	0		0	4,859,853	4,652,874	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	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	6.00
7.00	G	ST VINCENT HEAL	100.00	ST VINCENT HEAL	100.00	7.00
8.00	G	CATHOLIC HEALTH	100.00	CATHOLIC HEALTH	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: 151314	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-1 Date/Time Prepared: 11/18/2016 12:01 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	386,149	0		2.00
3.00	51,112	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	-208,670	0		4.06
4.07	-45,621	0		4.07
4.08	24,009	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
5.00	206,979			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOME OFFICE		6.00
7.00	HOME OFFICE		7.00
8.00	HOME OFFICE		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: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/18/2016 12:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	150,000	150,000	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	143,100	143,100	0	0	0	2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	165,704	165,704	0	0	0	3.00
4.00	75.01	SLEEP DISORDER	52,300	52,300	0	0	0	4.00
5.00	91.00	EMERGENCY	707,126	0	707,126	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			1,218,230	511,104	707,126		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	3.00
4.00	75.01	SLEEP DISORDER	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	91.00	EMERGENCY	0	0	0	150,000		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	143,100		2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	165,704		3.00
4.00	75.01	SLEEP DISORDER	0	0	0	52,300		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	511,104		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/18/2016 12:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,188	11,188				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,050,930	130	0	2,051,060		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,487,214	1,224	0	538,387	4,026,825	5.00
7.00	00700	OPERATION OF PLANT	1,282,933	1,819	0	0	1,284,752	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,872	0	0	0	50,872	8.00
9.00	00900	HOUSEKEEPING	307,165	341	0	0	307,506	9.00
10.00	01000	DIETARY	48,234	1,074	0	0	49,308	10.00
11.00	01100	CAFETERIA	234,389	0	0	0	234,389	11.00
13.00	01300	NURSING ADMINISTRATION	32,798	42	0	6,898	39,738	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	132,995	0	0	35,872	168,867	14.00
15.00	01500	PHARMACY	338,945	109	0	56,596	395,650	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	216,005	521	0	63,620	280,146	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	762,382	1,237	0	271,466	1,035,085	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	892,472	1,190	0	180,270	1,073,932	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	950,140	585	0	205,671	1,156,396	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	215,605	137	0	20,253	235,995	58.00
60.00	06000	LABORATORY	1,173,108	208	0	0	1,173,316	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0				0	61.00
65.00	06500	RESPIRATORY THERAPY	261,876	121	0	82,266	344,263	65.00
66.00	06600	PHYSICAL THERAPY	438,926	261	0	143,908	583,095	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,952	42	0	20,858	84,852	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	98,899	310	0	39,778	138,987	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	168,113	0	0	0	168,113	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	68,704	0	0	0	68,704	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	274,225	0	0	0	274,225	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	145,263	314	0	45,089	190,666	75.01
75.03	07501	ADULT MENTAL HEALTH	411,582	259	0	0	411,841	75.03
76.97	07697	CARDIAC REHABILITATION	87,344	146	0	26,282	113,772	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,580,261	499	0	252,440	1,833,200	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)	15,786,520	10,569	0	1,989,654	15,724,495	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	118,975	547	0	39,136	158,658	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	116,460	0	0	19,841	136,301	193.01
193.02	19302	NEW HORIZON OP	7,324	72	0	2,429	9,825	193.02
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)	16,029,279	11,188	0	2,051,060	16,029,279	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/18/2016 12:01 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	4,026,825					5.00
7.00	00700	OPERATION OF PLANT	431,034	1,715,786				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,068	0	67,940			8.00
9.00	00900	HOUSEKEEPING	103,168	73,051	0	483,725		9.00
10.00	01000	DIETARY	16,543	229,904	0	0	295,755	10.00
11.00	01100	CAFETERIA	78,638	0	0	6,663	0	11.00
13.00	01300	NURSING ADMINISTRATION	13,332	9,082	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	56,655	0	0	4,373	0	14.00
15.00	01500	PHARMACY	132,741	23,424	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93,989	111,442	0	4,789	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	347,271	264,681	11,706	103,284	295,755	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	360,304	254,787	11,215	116,195	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	387,971	125,250	8,145	34,775	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	79,176	29,308	0	0	0	58.00
60.00	06000	LABORATORY	393,648	44,623	0	23,322	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	115,500	25,810	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	195,628	55,906	9,323	16,242	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,468	8,966	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	46,630	66,402	3,079	16,034	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,402	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	23,050	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	92,002	0	0	6,455	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	63,968	67,305	1,562	24,988	0	75.01
75.03	07501	ADULT MENTAL HEALTH	138,173	55,350	0	19,990	0	75.03
76.97	07697	CARDIAC REHABILITATION	38,171	31,208	62	12,494	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	615,040	106,738	22,638	75,380	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)	3,924,570	1,583,237	67,730	464,984	295,755	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	3,123	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	53,230	117,072	210	14,785	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	45,729	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	3,296	15,477	0	833	0	193.02
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)	4,026,825	1,715,786	67,940	483,725	295,755	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/18/2016 12:01 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	319,690					11.00
13.00	01300	NURSING ADMINISTRATION	1,109	63,261				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,304	0	242,199			14.00
15.00	01500	PHARMACY	8,175	0	0	559,990		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,418	0	0	0	511,784	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,304	10,541	12,905	0	32,030	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,328	7,029	88,550	0	114,747	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	42,762	7,615	0	0	64,413	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,691	0	0	0	0	58.00
60.00	06000	LABORATORY	0	5,272	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	18,727	4,686	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	29,525	5,858	1,782	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,961	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,782	586	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	84,670	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	34,603	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,858	0	559,990	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	11,760	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	6,380	1,172	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	50,010	6,443	19,689	0	242,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	306,236	55,060	242,199	559,990	454,059	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,681	8,201	0	0	57,725	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	4,062	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	711	0	0	0	0	193.02
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)	319,690	63,261	242,199	559,990	511,784	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/18/2016 12:01 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	2,166,562	0	2,166,562		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,061,087	0	2,061,087		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,827,327	0	1,827,327		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	348,170	0	348,170		58.00
60.00	06000	LABORATORY	1,640,181	0	1,640,181		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0		61.00
65.00	06500	RESPIRATORY THERAPY	508,986	0	508,986		65.00
66.00	06600	PHYSICAL THERAPY	897,359	0	897,359		66.00
67.00	06700	OCCUPATIONAL THERAPY	125,247	0	125,247		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	281,500	0	281,500		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309,185	0	309,185		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	126,357	0	126,357		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	938,530	0	938,530		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	03950	SLEEP DISORDER	360,249	0	360,249		75.01
75.03	07501	ADULT MENTAL HEALTH	625,354	0	625,354		75.03
76.97	07697	CARDIAC REHABILITATION	203,259	0	203,259		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	2,972,007	0	2,972,007		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)	15,391,360	0	15,391,360		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,123	0	3,123		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	418,562	0	418,562		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	186,092	0	186,092		193.01
193.02	19302	NEW HORIZON OP	30,142	0	30,142		193.02
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)	16,029,279	0	16,029,279		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/18/2016 12:01 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	446	130	0	576	576	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	338,654	1,224	0	339,878	150	5.00
7.00	00700	OPERATION OF PLANT	33,737	1,819	0	35,556	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,672	341	0	2,013	0	9.00
10.00	01000	DIETARY	1,969	1,074	0	3,043	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,557	42	0	4,599	2	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,749	0	0	1,749	10	14.00
15.00	01500	PHARMACY	39,302	109	0	39,411	16	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,902	521	0	4,423	18	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,059	1,237	0	23,296	76	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,271	1,190	0	57,461	51	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	179,762	585	0	180,347	58	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	135,300	137	0	135,437	6	58.00
60.00	06000	LABORATORY	1,442	208	0	1,650	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				0		61.00
65.00	06500	RESPIRATORY THERAPY	10,728	121	0	10,849	23	65.00
66.00	06600	PHYSICAL THERAPY	592	261	0	853	40	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	42	0	42	6	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,738	310	0	3,048	11	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	326	314	0	640	13	75.01
75.03	07501	ADULT MENTAL HEALTH	0	259	0	259	0	75.03
76.97	07697	CARDIAC REHABILITATION	7,160	146	0	7,306	7	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	23,623	499	0	24,122	71	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)	865,989	10,569	0	876,558	558	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	652	547	0	1,199	11	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	1,749	0	0	1,749	6	193.01
193.02	19302	NEW HORIZON OP	0	72	0	72	1	193.02
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)	868,390	11,188	0	879,578	576	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/18/2016 12:01 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	340,028					5.00
7.00	00700	OPERATION OF PLANT	36,397	71,953				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,441	0	1,441			8.00
9.00	00900	HOUSEKEEPING	8,712	3,063	0	13,788		9.00
10.00	01000	DIETARY	1,397	9,641	0	0	14,081	10.00
11.00	01100	CAFETERIA	6,640	0	0	190	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,126	381	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,784	0	0	125	0	14.00
15.00	01500	PHARMACY	11,209	982	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,937	4,673	0	137	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,324	11,101	248	2,944	14,081	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,424	10,685	238	3,311	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	32,761	5,252	173	991	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,686	1,229	0	0	0	58.00
60.00	06000	LABORATORY	33,240	1,871	0	665	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	9,753	1,082	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	16,519	2,344	198	463	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,404	376	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,938	2,785	65	457	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,763	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,946	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,769	0	0	184	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	5,402	2,823	33	712	0	75.01
75.03	07501	ADULT MENTAL HEALTH	11,667	2,321	0	570	0	75.03
76.97	07697	CARDIAC REHABILITATION	3,223	1,309	1	356	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	51,932	4,476	481	2,149	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)	331,394	66,394	1,437	13,254	14,081	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	89	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,495	4,910	4	421	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	3,861	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	278	649	0	24	0	193.02
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)	340,028	71,953	1,441	13,788	14,081	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/18/2016 12:01 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	6,830					11.00
13.00	01300	NURSING ADMINISTRATION	24	6,132				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	263	0	6,931			14.00
15.00	01500	PHARMACY	175	0	0	51,793		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	458	0	0	0	17,646	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,139	1,021	369	0	1,104	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	733	681	2,535	0	3,956	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	914	738	0	0	2,221	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	79	0	0	0	0	58.00
60.00	06000	LABORATORY	0	511	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	400	454	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	631	568	51	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	63	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	209	57	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,423	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	990	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	568	0	51,793	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	251	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	136	114	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,068	625	563	0	8,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,543	5,337	6,931	51,793	15,656	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	185	795	0	0	1,990	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	87	0	0	0	0	193.01
193.02	19302	NEW HORIZON OP	15	0	0	0	0	193.02
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)	6,830	6,132	6,931	51,793	17,646	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/18/2016 12:01 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	84,703	0	84,703		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	110,075	0	110,075		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	223,455	0	223,455		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	143,437	0	143,437		58.00
60.00	06000	LABORATORY	37,937	0	37,937		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY					61.00
65.00	06500	RESPIRATORY THERAPY	22,561	0	22,561		65.00
66.00	06600	PHYSICAL THERAPY	21,667	0	21,667		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,891	0	2,891		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	10,570	0	10,570		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,186	0	7,186		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,936	0	2,936		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,314	0	60,314		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	03950	SLEEP DISORDER	9,874	0	9,874		75.01
75.03	07501	ADULT MENTAL HEALTH	14,817	0	14,817		75.03
76.97	07697	CARDIAC REHABILITATION	12,452	0	12,452		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	93,862	0	93,862		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)	858,737	0	858,737		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	89	0	89		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,010	0	14,010		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	5,703	0	5,703		193.01
193.02	19302	NEW HORIZON OP	1,039	0	1,039		193.02
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)	879,578	0	879,578		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/18/2016 12:01 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	103,359					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,202	0	6,119,566			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,305	0	1,606,329	-4,026,825	12,002,454	5.00
7.00	00700	OPERATION OF PLANT	16,796	0	0	0	1,284,752	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	50,872	8.00
9.00	00900	HOUSEKEEPING	3,153	0	0	0	307,506	9.00
10.00	01000	DIETARY	9,923	0	0	0	49,308	10.00
11.00	01100	CAFETERIA	0	0	0	0	234,389	11.00
13.00	01300	NURSING ADMINISTRATION	392	0	20,582	0	39,738	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	107,027	0	168,867	14.00
15.00	01500	PHARMACY	1,011	0	168,861	0	395,650	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,810	0	189,817	0	280,146	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,424	0	809,951	0	1,035,085	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,997	0	537,856	0	1,073,932	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	5,406	0	613,643	0	1,156,396	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,265	0	60,428	0	235,995	58.00
60.00	06000	LABORATORY	1,926	0	0	0	1,173,316	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				0		61.00
65.00	06500	RESPIRATORY THERAPY	1,114	0	245,450	0	344,263	65.00
66.00	06600	PHYSICAL THERAPY	2,413	0	429,367	0	583,095	66.00
67.00	06700	OCCUPATIONAL THERAPY	387	0	62,233	0	84,852	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,866	0	118,681	0	138,987	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	168,113	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	68,704	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	274,225	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	2,905	0	134,529	0	190,666	75.01
75.03	07501	ADULT MENTAL HEALTH	2,389	0	0	0	411,841	75.03
76.97	07697	CARDIAC REHABILITATION	1,347	0	78,415	0	113,772	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,607	0	753,184	0	1,833,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,638	0	5,936,353	-4,026,825	11,697,670	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,053	0	116,766	0	158,658	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	0	0	59,199	0	136,301	193.01
193.02	19302	NEW HORIZON OP	668	0	7,248	0	9,825	193.02
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)	11,188	0	2,051,060		4,026,825	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.108244	0.000000	0.335164		0.335500	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			576		340,028	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000094		0.028330	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/18/2016 12:01 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	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	74,056					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,223				8.00
9.00	00900	HOUSEKEEPING	3,153	0	2,323			9.00
10.00	01000	DIETARY	9,923	0	0	888		10.00
11.00	01100	CAFETERIA	0	0	32	0	164,549	11.00
13.00	01300	NURSING ADMINISTRATION	392	0	0	0	571	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	21	0	6,333	14.00
15.00	01500	PHARMACY	1,011	0	0	0	4,208	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,810	0	23	0	11,024	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,424	2,623	496	888	27,436	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,997	2,513	558	0	17,669	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	5,406	1,825	167	0	22,010	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,265	0	0	0	1,900	58.00
60.00	06000	LABORATORY	1,926	0	112	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	1,114	0	0	0	9,639	65.00
66.00	06600	PHYSICAL THERAPY	2,413	2,089	78	0	15,197	66.00
67.00	06700	OCCUPATIONAL THERAPY	387	0	0	0	1,524	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,866	690	77	0	5,035	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	31	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	2,905	350	120	0	6,053	75.01
75.03	07501	ADULT MENTAL HEALTH	2,389	0	96	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	1,347	14	60	0	3,284	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,607	5,072	362	0	25,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,335	15,176	2,233	888	157,624	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	15	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,053	47	71	0	4,468	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	0	0	0	0	2,091	193.01
193.02	19302	NEW HORIZON OP	668	0	4	0	366	193.02
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)	1,715,786	67,940	483,725	295,755	319,690	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.168764	4.462984	208.232889	333.057432	1.942826	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	71,953	1,441	13,788	14,081	6,830	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.971603	0.094659	5.935428	15.856982	0.041507	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/18/2016 12:01 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			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	108					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	480,887				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,454		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18	25,623	0	91		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12	175,816	0	326		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	13	0	0	183		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	9	0	0	0		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	8	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	10	3,538	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	168,113	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	68,704	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10	0	100	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	03950	SLEEP DISORDER	0	0	0	0		75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0		75.03
76.97	07697	CARDIAC REHABILITATION	2	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	11	39,093	0	690		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	94	480,887	100	1,290		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14	0	0	164		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	0	0	0	0		193.01
193.02	19302	NEW HORIZON OP	0	0	0	0		193.02
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)	63,261	242,199	559,990	511,784		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	585.750000	0.503651	5,599.900000	351.983494		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,132	6,931	51,793	17,646		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	56.777778	0.014413	517.930000	12.136176		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:01 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	2,166,562		2,166,562	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,061,087		2,061,087	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,827,327		1,827,327	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	348,170		348,170	0	0	58.00
60.00	06000	LABORATORY	1,640,181		1,640,181	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	508,986	0	508,986	0	0	65.00
66.00	06600	PHYSICAL THERAPY	897,359	0	897,359	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,247	0	125,247	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	281,500		281,500	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309,185		309,185	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	126,357		126,357	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	938,530		938,530	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950	SLEEP DISORDER	360,249		360,249	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	625,354		625,354	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	203,259		203,259	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,972,007		2,972,007	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	969,719		969,719		0	92.00
200.00		Subtotal (see instructions)	16,361,079	0	16,361,079	0	0	200.00
201.00		Less Observation Beds	969,719		969,719		0	201.00
202.00		Total (see instructions)	15,391,360	0	15,391,360	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	987,637		987,637			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	246,719	7,145,158	7,391,877	0.278831	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	142,423	11,962,527	12,104,950	0.150957	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,836	1,737,459	1,755,295	0.198354	0.000000	58.00
60.00	06000	LABORATORY	287,981	7,853,390	8,141,371	0.201463	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	74,546	739,417	813,963	0.625318	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	140,333	2,408,341	2,548,674	0.352089	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,674	339,731	369,405	0.339051	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	14,936	1,615,491	1,630,427	0.172654	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	161,377	1,400,850	1,562,227	0.197913	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	36,156	312,680	348,836	0.362225	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318,924	3,145,096	3,464,020	0.270937	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	03950	SLEEP DISORDER	0	997,510	997,510	0.361148	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0	1,230,284	1,230,284	0.508301	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0	173,754	173,754	1.169809	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	61,947	9,646,207	9,708,154	0.306135	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	31,670	702,351	734,021	1.321105	0.000000	92.00
200.00		Subtotal (see instructions)	2,552,159	51,410,246	53,962,405			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,552,159	51,410,246	53,962,405			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
75.01	03950	SLEEP DISORDER	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:01 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	2,166,562		2,166,562	0	2,166,562	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,061,087		2,061,087	0	2,061,087	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,827,327		1,827,327	0	1,827,327	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	348,170		348,170	0	348,170	58.00
60.00	06000	LABORATORY	1,640,181		1,640,181	0	1,640,181	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	508,986	0	508,986	0	508,986	65.00
66.00	06600	PHYSICAL THERAPY	897,359	0	897,359	0	897,359	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,247	0	125,247	0	125,247	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	281,500		281,500	0	281,500	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309,185		309,185	0	309,185	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	126,357		126,357	0	126,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	938,530		938,530	0	938,530	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950	SLEEP DISORDER	360,249		360,249	0	360,249	75.01
75.03	07501	ADULT MENTAL HEALTH	625,354		625,354	0	625,354	75.03
76.97	07697	CARDIAC REHABILITATION	203,259		203,259	0	203,259	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,972,007		2,972,007	0	2,972,007	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	969,719		969,719		969,719	92.00
200.00		Subtotal (see instructions)	16,361,079	0	16,361,079	0	16,361,079	200.00
201.00		Less Observation Beds	969,719		969,719		969,719	201.00
202.00		Total (see instructions)	15,391,360	0	15,391,360	0	15,391,360	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	987,637		987,637			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	246,719	7,145,158	7,391,877	0.278831	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	142,423	11,962,527	12,104,950	0.150957	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,836	1,737,459	1,755,295	0.198354	0.000000	58.00
60.00	06000	LABORATORY	287,981	7,853,390	8,141,371	0.201463	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	74,546	739,417	813,963	0.625318	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	140,333	2,408,341	2,548,674	0.352089	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,674	339,731	369,405	0.339051	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	14,936	1,615,491	1,630,427	0.172654	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	161,377	1,400,850	1,562,227	0.197913	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	36,156	312,680	348,836	0.362225	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318,924	3,145,096	3,464,020	0.270937	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	03950	SLEEP DISORDER	0	997,510	997,510	0.361148	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0	1,230,284	1,230,284	0.508301	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0	173,754	173,754	1.169809	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	61,947	9,646,207	9,708,154	0.306135	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	31,670	702,351	734,021	1.321105	0.000000	92.00
200.00		Subtotal (see instructions)	2,552,159	51,410,246	53,962,405			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,552,159	51,410,246	53,962,405			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/18/2016 12:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	61.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
75.01	03950	SLEEP DISORDER	0.000000	75.01
75.03	07501	ADULT MENTAL HEALTH	0.000000	75.03
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/18/2016 12:01 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	110,075	7,391,877	0.014891	53,409	795	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	223,455	12,104,950	0.018460	33,650	621	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	143,437	1,755,295	0.081717	6,004	491	58.00
60.00	06000	LABORATORY	37,937	8,141,371	0.004660	97,667	455	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	22,561	813,963	0.027717	19,751	547	65.00
66.00	06600	PHYSICAL THERAPY	21,667	2,548,674	0.008501	24,166	205	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,891	369,405	0.007826	2,569	20	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,570	1,630,427	0.006483	11,937	77	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,186	1,562,227	0.004600	49,485	228	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,936	348,836	0.008417	715	6	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,314	3,464,020	0.017412	114,604	1,995	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	9,874	997,510	0.009899	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	14,817	1,230,284	0.012044	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	12,452	173,754	0.071665	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	93,862	9,708,154	0.009668	2,329	23	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	37,912	734,021	0.051650	2,107	109	92.00
200.00		Total (lines 50-199)	811,946	52,974,768		418,393	5,572	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/18/2016 12:01 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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
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
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/18/2016 12:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,391,877	0.000000	0.000000	53,409	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	12,104,950	0.000000	0.000000	33,650	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,755,295	0.000000	0.000000	6,004	58.00
60.00	06000	LABORATORY	0	8,141,371	0.000000	0.000000	97,667	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	813,963	0.000000	0.000000	19,751	65.00
66.00	06600	PHYSICAL THERAPY	0	2,548,674	0.000000	0.000000	24,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	369,405	0.000000	0.000000	2,569	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,630,427	0.000000	0.000000	11,937	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,562,227	0.000000	0.000000	49,485	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	348,836	0.000000	0.000000	715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,464,020	0.000000	0.000000	114,604	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	03950	SLEEP DISORDER	0	997,510	0.000000	0.000000	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	1,230,284	0.000000	0.000000	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	173,754	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	9,708,154	0.000000	0.000000	2,329	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	734,021	0.000000	0.000000	2,107	92.00
200.00		Total (lines 50-199)	0	52,974,768			418,393	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/18/2016 12:01 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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY					61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	03950	SLEEP DISORDER	0	0	0		75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0		75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/18/2016 12:01 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	0.278831	0	1,869,518	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.150957	0	3,406,478	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.198354	0	494,865	0	0	58.00
60.00	06000	LABORATORY	0.201463	0	2,537,748	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		0	0		61.00
65.00	06500	RESPIRATORY THERAPY	0.625318	0	49,051	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.352089	0	652,716	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339051	0	68,543	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172654	0	903,582	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197913	0	429,231	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362225	0	85,084	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270937	0	1,206,129	3,780	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0.361148	0	293,168	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.508301	0	1,110,228	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	1.169809	0	48,476	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.306135	0	2,175,446	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.321105	0	291,734	0	0	92.00
200.00		Subtotal (see instructions)		0	15,621,997	3,780	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	15,621,997	3,780	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/18/2016 12:01 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	521,280	0		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	514,232	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	98,158	0		58.00
60.00	06000	LABORATORY	511,262	0		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0			61.00
65.00	06500	RESPIRATORY THERAPY	30,672	0		65.00
66.00	06600	PHYSICAL THERAPY	229,814	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	23,240	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	156,007	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,950	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	30,820	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	326,785	1,024		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03950	SLEEP DISORDER	105,877	0		75.01
75.03	07501	ADULT MENTAL HEALTH	564,330	0		75.03
76.97	07697	CARDIAC REHABILITATION	56,708	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	665,980	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	385,411	0		92.00
200.00		Subtotal (see instructions)	4,305,526	1,024		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,305,526	1,024		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151314 | Component CCN: 15Z314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/18/2016 12:01 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	0.278831	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.150957	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.198354	0	0	0	0	58.00
60.00	06000	LABORATORY	0.201463	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		0	0		61.00
65.00	06500	RESPIRATORY THERAPY	0.625318	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.352089	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339051	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172654	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197913	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362225	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270937	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0.361148	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.508301	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	1.169809	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.306135	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.321105	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: 151314 | Component CCN: 15Z314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/18/2016 12:01 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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0			61.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03950	SLEEP DISORDER	0	0		75.01
75.03	07501	ADULT MENTAL HEALTH	0	0		75.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/18/2016 12:01 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	84,703	14,978	69,725	949	73.47	30.00
200.00	Total (lines 30-199)	84,703		69,725	949		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	20	1,469				30.00
200.00	Total (lines 30-199)	20	1,469				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/18/2016 12:01 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	110,075	7,391,877	0.014891	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	223,455	12,104,950	0.018460	4,554	84	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	143,437	1,755,295	0.081717	0	0	58.00
60.00	06000	LABORATORY	37,937	8,141,371	0.004660	12,440	58	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	22,561	813,963	0.027717	479	13	65.00
66.00	06600	PHYSICAL THERAPY	21,667	2,548,674	0.008501	504	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,891	369,405	0.007826	376	3	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,570	1,630,427	0.006483	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,186	1,562,227	0.004600	3,230	15	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,936	348,836	0.008417	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,314	3,464,020	0.017412	9,161	160	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	9,874	997,510	0.009899	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	14,817	1,230,284	0.012044	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	12,452	173,754	0.071665	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	93,862	9,708,154	0.009668	1,399	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	37,912	734,021	0.051650	728	38	92.00
200.00		Total (lines 50-199)	811,946	52,974,768		32,871	389	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/18/2016 12:01 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
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	949	0.00	20	0		30.00
200.00		Total (lines 30-199)	949		20	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/18/2016 12:01 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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
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
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/18/2016 12:01 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	7,391,877	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	12,104,950	0.000000	0.000000	4,554	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,755,295	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	8,141,371	0.000000	0.000000	12,440	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	0	813,963	0.000000	0.000000	479	65.00
66.00	06600	PHYSICAL THERAPY	0	2,548,674	0.000000	0.000000	504	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	369,405	0.000000	0.000000	376	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,630,427	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,562,227	0.000000	0.000000	3,230	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	348,836	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,464,020	0.000000	0.000000	9,161	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	03950	SLEEP DISORDER	0	997,510	0.000000	0.000000	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0	1,230,284	0.000000	0.000000	0	75.03
76.97	07697	CARDIAC REHABILITATION	0	173,754	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	9,708,154	0.000000	0.000000	1,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	734,021	0.000000	0.000000	728	92.00
200.00		Total (lines 50-199)	0	52,974,768			32,871	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/18/2016 12:01 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
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY					61.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	03950	SLEEP DISORDER	0	0	0		75.01
75.03	07501	ADULT MENTAL HEALTH	0	0	0		75.03
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151314	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/18/2016 12:01 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)	1,177	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	949	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)	433	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	101	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)	101	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	26	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)	230	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)	101	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)	89	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)	2,166,562	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)	3,486	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)	383,105	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,783,457	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)	1,783,457	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)	1,879.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	432,239	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)	432,239	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/18/2016 12:01 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	109,231	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	541,470	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)	189,809	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	167,258	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	357,067	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)	516	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,879.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	969,719	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/18/2016 12:01 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	84,703	2,166,562	0.039096	969,719	37,912	90.00
91.00	Nursing School cost	0	2,166,562	0.000000	969,719	0	91.00
92.00	Allied health cost	0	2,166,562	0.000000	969,719	0	92.00
93.00	All other Medical Education	0	2,166,562	0.000000	969,719	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/18/2016 12:01 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)	1,177	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	949	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)	433	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	101	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)	101	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	26	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)	20	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.09	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.09	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,166,562	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)	3,486	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)	383,105	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,783,457	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)	1,783,457	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)	1,879.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	37,586	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)	37,586	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/18/2016 12:01 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,308	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	45,894	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)	516	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,879.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	969,719	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/18/2016 12:01 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	84,703	2,166,562	0.039096	969,719	37,912	90.00
91.00	Nursing School cost	0	2,166,562	0.000000	969,719	0	91.00
92.00	Allied health cost	0	2,166,562	0.000000	969,719	0	92.00
93.00	All other Medical Education	0	2,166,562	0.000000	969,719	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/18/2016 12:01 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		216,499		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.278831	53,409	14,892	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.150957	33,650	5,080	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.198354	6,004	1,191	58.00
60.00	06000	LABORATORY	0.201463	97,667	19,676	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0.625318	19,751	12,351	65.00
66.00	06600	PHYSICAL THERAPY	0.352089	24,166	8,509	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339051	2,569	871	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172654	11,937	2,061	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197913	49,485	9,794	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362225	715	259	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270937	114,604	31,050	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	0.361148	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.508301	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	1.169809	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.306135	2,329	713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.321105	2,107	2,784	92.00
200.00		Total (sum of lines 50-94 and 96-98)		418,393	109,231	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)		418,393		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151314 | Component CCN: 15Z314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/18/2016 12:01 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.278831	1,379	385	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.150957	11,242	1,697	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.198354	0	0	58.00
60.00	06000	LABORATORY	0.201463	29,552	5,954	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0.625318	748	468	65.00
66.00	06600	PHYSICAL THERAPY	0.352089	85,109	29,966	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339051	19,255	6,528	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172654	2,999	518	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197913	3,124	618	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362225	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270937	43,810	11,870	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	0.361148	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.508301	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	1.169809	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.306135	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.321105	492	650	92.00
200.00		Total (sum of lines 50-94 and 96-98)		197,710	58,654	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)		197,710		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/18/2016 12:01 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		25,512		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.278831	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.150957	4,554	687	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.198354	0	0	58.00
60.00	06000	LABORATORY	0.201463	12,440	2,506	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0.625318	479	300	65.00
66.00	06600	PHYSICAL THERAPY	0.352089	504	177	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339051	376	127	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.172654	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.197913	3,230	639	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.362225	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270937	9,161	2,482	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950	SLEEP DISORDER	0.361148	0	0	75.01
75.03	07501	ADULT MENTAL HEALTH	0.508301	0	0	75.03
76.97	07697	CARDIAC REHABILITATION	1.169809	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.306135	1,399	428	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.321105	728	962	92.00
200.00		Total (sum of lines 50-94 and 96-98)		32,871	8,308	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)		32,871		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151314	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/18/2016 12:01 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,306,550	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)	4,306,550	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)	4,349,616	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	39,315	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,673,499	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)	1,636,802	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)	1,636,802	30.00
31.00	Primary payer payments	943	31.00
32.00	Subtotal (line 30 minus line 31)	1,635,859	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)	938,982	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	610,338	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	773,128	36.00
37.00	Subtotal (see instructions)	2,246,197	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.01		0	39.01
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,246,197	40.00
40.01	Sequestration adjustment (see instructions)	44,924	40.01
41.00	Interim payments	2,761,382	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-560,109	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: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/18/2016 12:01 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		536,463		2,761,382	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
3.49			0		0	3.49
	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)		536,463		2,761,382	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		62,985		560,109	6.02
7.00	Total Medicare program liability (see instructions)		473,478		2,201,273	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: 151314 | Component CCN: 15Z314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/18/2016 12:01 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		437,345		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
3.49			0		0	3.49
	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)		437,345		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		27,716		0	6.02
7.00	Total Medicare program liability (see instructions)		409,629		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: 151314 Component CCN: 15Z314	Period: From 07/01/2015 To 06/30/2016	Worksheet E-2 Date/Time Prepared: 11/18/2016 12:01 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)	360,638	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)	59,241	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	190	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)	419,879	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	419,879	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)	419,879	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,890	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)	417,989	0	15.00
16.00		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	417,989	0	19.00
19.01	Sequestration adjustment (see instructions)	8,360	0	19.01
20.00	Interim payments	437,345	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)	-27,716	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: 151314	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/18/2016 12:01 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	541,470	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)	541,470	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	546,885	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)	546,885	19.00
20.00	Deductibles (exclude professional component)	72,505	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	474,380	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	474,380	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13,478	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	8,761	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8,450	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	483,141	28.00
29.00		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	483,141	30.00
30.01	Sequestration adjustment (see instructions)	9,663	30.01
31.00	Interim payments	536,463	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)	-62,985	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: 151314	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/18/2016 12:01 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	45,894		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)	45,894	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)	45,894	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	25,512		8.00
9.00	Ancillary service charges	32,871	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)	58,383	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)	58,383	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	12,489	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)	45,894	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)	45,894	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)	45,894	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)	45,894	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	45,894	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)	45,894	0	40.00
41.00	Interim payments	45,894	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: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/18/2016 12:01 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	7,404,469	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,920,405	0	0	0	4.00
5.00	Other receivable	592,708	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,867,396	0	0	0	6.00
7.00	Inventory	356,804	0	0	0	7.00
8.00	Prepaid expenses	180,614	0	0	0	8.00
9.00	Other current assets	50,300	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)	10,637,904	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	180,000	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	1,187,750	0	0	0	15.00
16.00	Accumulated depreciation	-147,786	0	0	0	16.00
17.00	Leasehold improvements	859,079	0	0	0	17.00
18.00	Accumulated depreciation	-857,035	0	0	0	18.00
19.00	Fixed equipment	620,016	0	0	0	19.00
20.00	Accumulated depreciation	-511,229	0	0	0	20.00
21.00	Automobiles and trucks	13,500	0	0	0	21.00
22.00	Accumulated depreciation	-13,500	0	0	0	22.00
23.00	Major movable equipment	1,755,367	0	0	0	23.00
24.00	Accumulated depreciation	-652,530	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)	2,433,632	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8,659	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,659	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,080,195	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	616,082	0	0	0	37.00
38.00	Salaries, wages, and fees payable	603,530	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-38,207	0	0	0	43.00
44.00	Other current liabilities	1,883,716	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,065,121	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,065,121	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,015,074				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)	10,015,074	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,080,195	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/18/2016 12:01 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		10,347,672		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,368,279				2.00
3.00	Total (sum of line 1 and line 2)		11,715,951		0		3.00
4.00		0		0		0	4.00
5.00	DONATION	1,360		0		0	5.00
6.00	GRANT REVENUE	9,988		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		11,348		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,727,299		0		11.00
12.00	TRANSFER FROM AFFILIATES	1,685,584		0		0	12.00
13.00	PENSION ADJUSTMENT	24,266		0		0	13.00
14.00		0		0		0	14.00
15.00	RELEASED OPERATING	2,375		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)		1,712,225		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,015,074		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			0			4.00
5.00	DONATION		0			5.00
6.00	GRANT REVENUE		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	TRANSFER FROM AFFILIATES		0			12.00
13.00	PENSION ADJUSTMENT		0			13.00
14.00			0			14.00
15.00	RELEASED OPERATING		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: 151314 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/18/2016 12:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,966,362		2,966,362	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,966,362		2,966,362	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,966,362		2,966,362	17.00
18.00	Ancillary services	1,466,903	39,324,759	40,791,662	18.00
19.00	Outpatient services	93,617	10,110,764	10,204,381	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER OPERATING REVENUE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,526,882	49,435,523	53,962,405	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,595,044		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,595,044		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151314	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/18/2016 12:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,962,405	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,993,794	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,968,611	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,595,044	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,373,567	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-220,490	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	69,904	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	102,595	22.00
23.00	Governmental appropriations	0	23.00
24.00		0	24.00
24.01	OTHER	32,132	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	2,375	24.02
24.03		0	24.03
24.04		0	24.04
24.05	GRANT REVENUE	8,196	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	-5,288	25.00
26.00	Total (line 5 plus line 25)	1,368,279	26.00
27.00		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)	1,368,279	29.00