This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1309	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/27/2017 5:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/27/2017 Time: 5:05 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT CLAY HOSPITAL (15-1309) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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	190,913	35,692	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	113,722	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	304,635	35,692	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: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2017 12:49 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1206 EAST NATIONAL AVENUE	PO Box:			1.00
2.00	City: BRAZIL	State: IN	Zip Code: 47834	County: CLAY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT CLAY HOSPITAL	151309	45460	1	08/08/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT CLAY SWING BEDS	15Z309	45460		08/08/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2016	06/30/2017	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 12:49 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2017 12:49 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: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 12:49 pm

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	54,168	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: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 12:49 pm

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	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: 15-1309	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 12:49 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	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 12:49 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	10/02/2017	Y	10/02/2017
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 12:49 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519		JILL.HILL1@ASCENSION.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1309	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 12:49 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/27/2017 12:49 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	9,125	24,216.00	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	9,125	24,216.00	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	9,125	24,216.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2017 12:49 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)	577	8	1,009			1.00
2.00	HMO and other (see instructions)	51	189				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	472	0	510			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	14			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,049	8	1,533			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,049	8	1,533	0.00	99.30	14.00
15.00	CAH visits	11,322	526	33,188			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	99.30	27.00
28.00	Observation Bed Days		0	404			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: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/27/2017 12:49 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	171	7	310	1.00
2.00	HMO and other (see instructions)			14	53		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	171	7	310	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/27/2017 12:49 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)	0.276752	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	913,149	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	16,261,565	6.00
7.00	Medicaid cost (line 1 times line 6)	4,500,421	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,587,272	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	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
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,587,272	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,979,491	655,520	3,635,011	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	824,580	655,520	1,480,100	21.00
22.00	Payments received from patients for amounts previously written off as charity care	129,794	47,890	177,684	22.00
23.00	Cost of charity care (line 21 minus line 22)	694,786	607,630	1,302,416	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, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	792,031	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	438,072	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	673,956	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	118,075	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	268,561	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,570,977	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,158,249	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/27/2017 12:49 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		521,345	521,345	-147,385	373,960	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		557,216	557,216	143,714	700,930	2.00
2.01	00201	CAP REL COSTS-MOB		209,475	209,475	0	209,475	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	17,550	1,763,976	1,781,526	0	1,781,526	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,670,842	2,318,174	3,989,016	6,190	3,995,206	5.00
7.00	00700	OPERATION OF PLANT	73,578	875,060	948,638	0	948,638	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,011	45,011	0	45,011	8.00
9.00	00900	HOUSEKEEPING	0	365,023	365,023	0	365,023	9.00
10.00	01000	DIETARY	0	383,933	383,933	-216,769	167,164	10.00
11.00	01100	CAFETERIA	0	0	0	216,769	216,769	11.00
13.00	01300	NURSING ADMINISTRATION	281,824	17,079	298,903	0	298,903	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,756	37,756	0	37,756	14.00
15.00	01500	PHARMACY	0	879,456	879,456	0	879,456	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	313,449	90,868	404,317	0	404,317	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	948,322	119,575	1,067,897	-1,289	1,066,608	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	419,242	379,212	798,454	-63,103	735,351	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	762,949	604,611	1,367,560	-2,152	1,365,408	54.00
60.00	06000	LABORATORY	24,416	1,029,944	1,054,360	-62	1,054,298	60.00
65.00	06500	RESPIRATORY THERAPY	167,850	22,309	190,159	0	190,159	65.00
66.00	06600	PHYSICAL THERAPY	0	681,291	681,291	-143,108	538,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	144,067	144,067	67.00
68.00	06800	SPEECH PATHOLOGY	0	76,889	76,889	0	76,889	68.00
69.00	06900	ELECTROCARDIOLOGY	131,612	39,129	170,741	0	170,741	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	79,240	79,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	118,193	118,193	0	118,193	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	873,567	1,267,811	2,141,378	-10,952	2,130,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,685,201	12,403,336	18,088,537	5,160	18,093,697	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,102	13,102	-5,160	7,942	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	97	97	0	97	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	209	1,046	1,255	0	1,255	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	227,040	227,040	0	227,040	193.07
200.00		TOTAL (SUM OF LINES 118-199)	5,685,410	12,644,621	18,330,031	0	18,330,031	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/27/2017 12:49 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	-126,801	247,159		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-135,525	565,405		2.00
2.01	00201	CAP REL COSTS-MOB	0	209,475		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-82,756	1,698,770		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-283,233	3,711,973		5.00
7.00	00700	OPERATION OF PLANT	-3,158	945,480		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,011		8.00
9.00	00900	HOUSEKEEPING	0	365,023		9.00
10.00	01000	DIETARY	0	167,164		10.00
11.00	01100	CAFETERIA	-32,017	184,752		11.00
13.00	01300	NURSING ADMINISTRATION	0	298,903		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,756		14.00
15.00	01500	PHARMACY	-1,929	877,527		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4	404,313		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,066,608		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	735,351		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-43,839	1,321,569		54.00
60.00	06000	LABORATORY	0	1,054,298		60.00
65.00	06500	RESPIRATORY THERAPY	0	190,159		65.00
66.00	06600	PHYSICAL THERAPY	-565	537,618		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	144,067		67.00
68.00	06800	SPEECH PATHOLOGY	0	76,889		68.00
69.00	06900	ELECTROCARDIOLOGY	0	170,741		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79,240		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	118,193		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-150,000	1,980,426		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-859,827	17,233,870		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,942		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0		193.01
193.02	19302	PUBLIC RELATIONS	0	97		193.02
193.03	19303	FOUNDATION	0	0		193.03
193.04	19304	MISSION SERVICES	0	1,255		193.04
193.05	19305	OTHER NON-REIMBURSABLE	88,915	88,915		193.05
193.06	19306	ENTERTAINMENT	0	0		193.06
193.07	19307	MARKETING	0	227,040		193.07
200.00		TOTAL (SUM OF LINES 118-199)	-770,912	17,559,119		200.00

RECLASSIFICATIONS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/27/2017 12:49 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MEDICAL OFFICE BUILDING				
1.00	OCCUPATIONAL THERAPY	67.00	0	292	1.00
2.00	PHYSICAL THERAPY	66.00	0	1,442	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	907	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	2,519	4.00
	TOTALS		0	5,160	
	B - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,671	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	135,525	2.00
	TOTALS		0	139,196	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	0	216,769	1.00
	TOTALS		0	216,769	
	D - PROPERTY INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,189	1.00
	TOTALS		0	8,189	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	79,240	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	79,240	
	F - OT RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	0	143,775	1.00
	TOTALS		0	143,775	
500.00	Grand Total: Increases		0	592,329	500.00

RECLASSIFICATIONS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/27/2017 12:49 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL OFFICE BUILDING						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,160	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	5,160			
	B - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,671	11		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	135,525	11		2.00
	TOTALS		0	139,196			
	C - CAFETERIA						
1.00	DIETARY	10.00	0	216,769	0		1.00
	TOTALS		0	216,769			
	D - PROPERTY INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,189	11		1.00
	TOTALS		0	8,189			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	1,289	0		1.00
2.00	OPERATING ROOM	50.00	0	63,103	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,059	0		3.00
4.00	LABORATORY	60.00	0	62	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	775	0		5.00
6.00	EMERGENCY	91.00	0	10,952	0		6.00
	TOTALS		0	79,240			
	F - OT RECLASS						
1.00	PHYSICAL THERAPY	66.00	0	143,775	0		1.00
	TOTALS		0	143,775			
500.00	Grand Total: Decreases		0	592,329			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/27/2017 12:49 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,500	0	0	0	0	1.00
2.00	Land Improvements	192,578	0	0	0	0	2.00
3.00	Buildings and Fixtures	8,937,861	396,587	0	396,587	0	3.00
4.00	Building Improvements	995,040	0	0	0	0	4.00
5.00	Fixed Equipment	2,877,354	101,878	0	101,878	0	5.00
6.00	Movable Equipment	7,252,173	0	0	0	82,414	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,257,506	498,465	0	498,465	82,414	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,257,506	498,465	0	498,465	82,414	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,500	0	1.00
2.00	Land Improvements	192,578	0	2.00
3.00	Buildings and Fixtures	9,334,448	0	3.00
4.00	Building Improvements	995,040	0	4.00
5.00	Fixed Equipment	2,979,232	0	5.00
6.00	Movable Equipment	7,169,759	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,673,557	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	20,673,557	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/27/2017 12:49 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	239,496	0	265,998	15,851	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	477,971	78,898	0	347	0	2.00
2.01	CAP REL COSTS-MOB	0	209,475	0	0	0	2.01
3.00	Total (sum of lines 1-2)	717,467	288,373	265,998	16,198	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	521,345	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	557,216	2.00
2.01	CAP REL COSTS-MOB	0	209,475	2.01
3.00	Total (sum of lines 1-2)	0	1,288,036	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/27/2017 12:49 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	10,524,566	0	10,524,566	0.509083	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,148,991	0	10,148,991	0.490917	0	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	20,673,557	0	20,673,557	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	112,695	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	342,446	78,898	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0	209,475	2.01
3.00	Total (sum of lines 1-2)	0	0	0	455,141	288,373	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	118,613	15,851	0	0	247,159	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	143,714	347	0	0	565,405	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0	209,475	2.01
3.00	Total (sum of lines 1-2)	262,327	16,198	0	0	1,022,039	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/27/2017 12:49 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-126,125	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-134,804	CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
2.01	Investment income - CAP REL COSTS-MOB (chapter 2)		0	CAP REL COSTS-MOB	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-3,652	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-193,839			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	211,695			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-32,017	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,929	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB		0	CAP REL COSTS-MOB	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/27/2017 12:49 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ACCRUED INCENTIVE	A	111,215	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISC. INCOME - MISSION POINT	B	-7,502	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISC. INCOME - A&G	B	-108	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.04	ENTERTAINMENT	A	-333	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.08	LOBBYING	A	-774	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	DONATIONS	A	-18,493	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MARKETING	A	-565	PHYSICAL THERAPY	66.00	0	33.10
33.11	NON-REIMBURSABLE ENTERTAINMENT	A	-4,942	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PROVIDER TAX	B	-568,735	ADMINISTRATIVE & GENERAL	5.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-770,912				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/27/2017 12:49 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	0	56,961	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,058,057	744,234	2.00
3.00	193.05	OTHER NON-REIMBURSABLE	HOME OFFICE	88,915	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION CHARGEBACK	357,241	357,241	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACK	1,712,097	1,712,097	3.02
4.00	7.00	OPERATION OF PLANT	ASCENSION CHARGEBACK	80,321	80,321	4.00
4.01	13.00	NURSING ADMINISTRATION	ASCENSION CHARGEBACK	68,557	68,557	4.01
4.02	15.00	PHARMACY	ASCENSION CHARGEBACK	22,500	22,500	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	ASCENSION CHARGEBACK	398,667	398,667	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	ASCENSION CHARGEBACK	28,450	28,450	4.04
4.05	69.00	ELECTROCARDIOLOGY	ASCENSION CHARGEBACK	1,400	1,400	4.05
4.06	91.00	EMERGENCY	ASCENSION CHARGEBACK	175	175	4.06
4.07	0.00			0	0	4.07
4.08	0.00			0	0	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
4.14	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF-INSURANCE	706,856	975,617	4.14
4.15	0.00			0	0	4.15
4.16	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	126,125	126,801	4.16
4.17	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION INTEREST	134,804	135,525	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	3,652	3,671	4.18
4.19	0.00			0	0	4.19
4.20	7.00	OPERATION OF PLANT	MEDXCEL	433,462	436,620	4.20
4.21	0.00			0	0	4.21
4.22	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	166,515	27,262	4.22
5.00	0		0	5,387,794	5,176,099	5.00

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

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

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	B	ST. VINCENT HOS	100.00	ST. VINCENT HOS	100.00	7.00
8.00	G	ASCENSION	100.00	ASCENSION	100.00	8.00
9.00	A	MEDXCEL	0.00	MEDXCEL	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: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/27/2017 12:49 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	-56,961	0		1.00
2.00	313,823	0		2.00
3.00	88,915	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	-268,761	0		4.14
4.15	0	0		4.15
4.16	-676	9		4.16
4.17	-721	9		4.17
4.18	-19	0		4.18
4.19	0	0		4.19
4.20	-3,158	0		4.20
4.21	0	0		4.21
4.22	139,253	0		4.22
5.00	211,695			5.00

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

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

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

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

6.00	ADMINISTRATION		6.00
7.00	HOSPITAL		7.00
8.00	ADMINISTRATION		8.00
9.00	TECHNOLOGY MGMT		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/27/2017 12:49 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	910,487	0	910,487	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	43,839	43,839	0	0	0	2.00
3.00	91.00	EMERGENCY	150,000	150,000	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,104,326	193,839	910,487		0	200.00

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

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	0		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	43,839		2.00
3.00	91.00	EMERGENCY	0	0	0	150,000		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	193,839		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 12:49 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					304	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					13	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,574.00	3,427.00	3,082.00	4,562.00	0.00	9.00
10.00	AHSEA (see instructions)	93.44	81.26	52.82	25.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.63	40.63	26.41			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					147,075	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					278,478	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					162,791	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					588,344	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					114,050	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					702,394	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					702,394	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					12,352	24.00
25.00	Assistants (line 4 times column 3, line 11)					343	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					12,695	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					3,034	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					15,729	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					15,729	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2017 12:49 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.26	52.82	25.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	702,394		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	15,729		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	718,123		63.00
64.00	Total cost of outside supplier services (from your records)	523,905		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	12,695		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	3,034		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	15,729		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	3,034		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	3,034		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1309	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 12:49 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		248	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		6.40	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,217.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.03	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.52	38.52	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	170,776	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	170,776	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	170,776	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	170,776	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	9,553	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	9,553	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,587	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	11,140	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	11,140	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2017 12:49 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.03	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	170,776	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	11,140	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	181,916	63.00
64.00	Total cost of outside supplier services (from your records)	143,775	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	9,553	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,587	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	11,140	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,587	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,587	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 12:49 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					189	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,111.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.04	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.02	37.02	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					82,258	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					82,258	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					82,258	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					82,258	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					6,997	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					6,997	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,210	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					8,207	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					8,207	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2017 12:49 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.04	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	82,258	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,207	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	90,465	63.00
64.00	Total cost of outside supplier services (from your records)	76,889	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	6,997	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,210	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,207	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,210	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,210	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP	MOB		
			0	1.00	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	247,159	247,159				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	565,405		565,405			2.00
2.01	00201	CAP REL COSTS-MOB	209,475		0	209,475		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,698,770	0	0	0	1,698,770	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,711,973	92,291	210,783	43,315	500,783	5.00
7.00	00700	OPERATION OF PLANT	945,480	50,722	116,032	0	22,053	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,011	5,301	12,128	0	0	8.00
9.00	00900	HOUSEKEEPING	365,023	2,940	6,725	0	0	9.00
10.00	01000	DIETARY	167,164	6,530	14,938	0	0	10.00
11.00	01100	CAFETERIA	184,752	3,704	8,474	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	298,903	5,787	13,238	0	84,468	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,756	0	0	0	0	14.00
15.00	01500	PHARMACY	877,527	2,901	6,636	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	404,313	25,719	58,835	0	93,947	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,066,608	16,695	38,193	0	284,231	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	735,351	6,854	15,679	0	125,655	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,321,569	4,753	10,873	14,507	228,671	54.00
60.00	06000	LABORATORY	1,054,298	3,887	8,892	0	7,318	60.00
65.00	06500	RESPIRATORY THERAPY	190,159	4,687	10,722	0	50,308	65.00
66.00	06600	PHYSICAL THERAPY	537,618	0	0	27,725	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,067	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	76,889	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	170,741	0	0	0	39,447	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,240	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,193	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,980,426	13,753	31,461	0	261,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,233,870	246,524	563,609	85,547	1,698,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	635	1,453	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,942	0	0	123,928	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	97	0	343	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	1,255	0	0	0	63	193.04
193.05	19305	OTHER NON-REIMBURSABLE	88,915	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	227,040	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,559,119	247,159	565,405	209,475	1,698,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,559,145	4,559,145				5.00
7.00	00700	OPERATION OF PLANT	1,134,287	397,799	1,532,086			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	62,440	21,898	67,993	152,331		8.00
9.00	00900	HOUSEKEEPING	374,688	131,405	37,705	2,310	546,108	9.00
10.00	01000	DIETARY	188,632	66,154	83,751	0	0	10.00
11.00	01100	CAFETERIA	196,930	69,064	47,507	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	402,396	141,122	74,219	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,756	13,241	0	0	0	14.00
15.00	01500	PHARMACY	887,064	311,097	37,206	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	582,814	204,395	329,858	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,405,727	492,994	214,125	35,262	156,031	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	883,539	309,861	87,902	27,515	104,021	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,580,373	554,243	128,414	16,346	52,010	54.00
60.00	06000	LABORATORY	1,074,395	376,795	49,851	0	26,005	60.00
65.00	06500	RESPIRATORY THERAPY	255,876	89,737	60,113	0	0	65.00
66.00	06600	PHYSICAL THERAPY	565,343	198,268	128,913	6,318	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,067	50,525	0	1,508	0	67.00
68.00	06800	SPEECH PATHOLOGY	76,889	26,965	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	210,188	73,714	0	3,041	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,240	27,790	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,193	41,451	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,287,466	802,225	176,381	55,738	156,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,107,448	4,400,743	1,523,938	148,038	494,098	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,088	732	8,148	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	131,870	46,247	0	4,293	52,010	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	440	154	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	1,318	462	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	88,915	31,183	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	227,040	79,624	0	0	0	193.07
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,559,119	4,559,145	1,532,086	152,331	546,108	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	338,537					10.00
11.00	01100	CAFETERIA	0	313,501				11.00
13.00	01300	NURSING ADMINISTRATION	0	18,622	636,359			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	50,997		14.00
15.00	01500	PHARMACY	0	0	0	0	1,235,367	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,419	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	338,537	75,999	276,531	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	34,611	126,100	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	60,448	0	0	0	54.00
60.00	06000	LABORATORY	0	4,875	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,576	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	9,798	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	50,997	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,235,367	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	64,153	233,728	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	338,537	313,501	636,359	50,997	1,235,367	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	338,537	313,501	636,359	50,997	1,235,367	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,147,486					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,868	3,049,074	0	3,049,074		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	120,145	1,693,694	0	1,693,694		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	371,813	2,763,647	0	2,763,647		54.00
60.00	06000	LABORATORY	190,385	1,722,306	0	1,722,306		60.00
65.00	06500	RESPIRATORY THERAPY	28,806	449,108	0	449,108		65.00
66.00	06600	PHYSICAL THERAPY	51,838	950,680	0	950,680		66.00
67.00	06700	OCCUPATIONAL THERAPY	15,167	211,267	0	211,267		67.00
68.00	06800	SPEECH PATHOLOGY	3,945	107,799	0	107,799		68.00
69.00	06900	ELECTROCARDIOLOGY	46,574	343,315	0	343,315		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	158,027	0	158,027		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	159,644	0	159,644		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,235,367	0	1,235,367		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	264,945	4,040,667	0	4,040,667		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,147,486	16,884,595	0	16,884,595		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,968	0	10,968		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	234,420	0	234,420		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0		193.01
193.02	19302	PUBLIC RELATIONS	0	594	0	594		193.02
193.03	19303	FOUNDATION	0	0	0	0		193.03
193.04	19304	MISSION SERVICES	0	1,780	0	1,780		193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	120,098	0	120,098		193.05
193.06	19306	ENTERTAINMENT	0	0	0	0		193.06
193.07	19307	MARKETING	0	306,664	0	306,664		193.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,147,486	17,559,119	0	17,559,119		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	CAPITAL RELATED COSTS MOB	Subtotal	
			0	1.00	2.00	2.01	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	314,441	92,291	210,783	43,315	660,830	5.00
7.00	00700	OPERATION OF PLANT	0	50,722	116,032	0	166,754	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,301	12,128	0	17,429	8.00
9.00	00900	HOUSEKEEPING	0	2,940	6,725	0	9,665	9.00
10.00	01000	DIETARY	0	6,530	14,938	0	21,468	10.00
11.00	01100	CAFETERIA	0	3,704	8,474	0	12,178	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,787	13,238	0	19,025	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	2,901	6,636	0	9,537	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,719	58,835	0	84,554	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	16,695	38,193	0	54,888	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,854	15,679	0	22,533	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,753	10,873	14,507	30,133	54.00
60.00	06000	LABORATORY	0	3,887	8,892	0	12,779	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,687	10,722	0	15,409	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	27,725	27,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	13,753	31,461	0	45,214	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)	314,441	246,524	563,609	85,547	1,210,121	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	635	1,453	0	2,088	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	123,928	123,928	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	343	0	343	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	314,441	247,159	565,405	209,475	1,336,480	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	660,830				5.00
7.00	00700	OPERATION OF PLANT	0	57,659	224,413			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,174	9,959	30,562		8.00
9.00	00900	HOUSEKEEPING	0	19,047	5,523	463	34,698	9.00
10.00	01000	DIETARY	0	9,589	12,268	0	0	10.00
11.00	01100	CAFETERIA	0	10,011	6,959	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	20,455	10,871	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,919	0	0	0	14.00
15.00	01500	PHARMACY	0	45,092	5,450	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,626	48,314	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	71,457	31,364	7,075	9,913	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,913	12,876	5,520	6,609	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	80,335	18,809	3,279	3,305	54.00
60.00	06000	LABORATORY	0	54,615	7,302	0	1,652	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,007	8,805	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	28,738	18,883	1,268	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,323	0	303	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,908	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,684	0	610	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,028	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,008	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	116,283	25,836	11,183	9,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	637,871	223,219	29,701	31,393	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	106	1,194	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,703	0	861	3,305	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	22	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	67	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	4,520	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	11,541	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	660,830	224,413	30,562	34,698	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	43,325					10.00
11.00	01100	CAFETERIA	0	29,148				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,731	52,082			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,919		14.00
15.00	01500	PHARMACY	0	0	0	0	60,079	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,828	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,325	7,067	22,633	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,218	10,320	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,620	0	0	0	54.00
60.00	06000	LABORATORY	0	453	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,355	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	911	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	1,919	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	60,079	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	5,965	19,129	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,325	29,148	52,082	1,919	60,079	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	43,325	29,148	52,082	1,919	60,079	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	165,322					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,762	255,484	0	255,484		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,312	123,301	0	123,301		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,555	195,036	0	195,036		54.00
60.00	06000	LABORATORY	27,433	104,234	0	104,234		60.00
65.00	06500	RESPIRATORY THERAPY	4,151	42,727	0	42,727		65.00
66.00	06600	PHYSICAL THERAPY	7,469	84,083	0	84,083		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,185	9,811	0	9,811		67.00
68.00	06800	SPEECH PATHOLOGY	568	4,476	0	4,476		68.00
69.00	06900	ELECTROCARDIOLOGY	6,711	18,916	0	18,916		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,947	0	5,947		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,008	0	6,008		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	60,079	0	60,079		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	38,176	271,700	0	271,700		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)	165,322	1,181,802	0	1,181,802		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,388	0	3,388		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	134,797	0	134,797		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0		193.01
193.02	19302	PUBLIC RELATIONS	0	365	0	365		193.02
193.03	19303	FOUNDATION	0	0	0	0		193.03
193.04	19304	MISSION SERVICES	0	67	0	67		193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	4,520	0	4,520		193.05
193.06	19306	ENTERTAINMENT	0	0	0	0		193.06
193.07	19307	MARKETING	0	11,541	0	11,541		193.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	165,322	1,336,480	0	1,336,480		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	CAPITAL RELATED COSTS MOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	2.00	2.01	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,473					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		82,473				2.00
2.01	00201	CAP REL COSTS-MOB		0	25,341			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	5,667,860		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,796	30,746	5,240	1,670,842	-4,559,145	5.00
7.00	00700	OPERATION OF PLANT	16,925	16,925	0	73,578	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,769	1,769	0	0	0	8.00
9.00	00900	HOUSEKEEPING	981	981	0	0	0	9.00
10.00	01000	DIETARY	2,179	2,179	0	0	0	10.00
11.00	01100	CAFETERIA	1,236	1,236	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,931	1,931	0	281,824	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	968	968	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,582	8,582	0	313,449	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,571	5,571	0	948,322	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,287	2,287	0	419,242	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,586	1,586	1,755	762,949	0	54.00
60.00	06000	LABORATORY	1,297	1,297	0	24,416	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,564	1,564	0	167,850	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,354	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	131,612	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,589	4,589	0	873,567	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	82,261	82,211	10,349	5,667,651	-4,559,145	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	212	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	14,992	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	50	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	209	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	247,159	565,405	209,475	1,698,770		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.996847	6.855638	8.266248	0.299720		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,999,974					5.00
7.00	00700	OPERATION OF PLANT	1,134,287	39,861				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	62,440	1,769	93,108			8.00
9.00	00900	HOUSEKEEPING	374,688	981	1,412	10,920		9.00
10.00	01000	DIETARY	188,632	2,179	0	0	100	10.00
11.00	01100	CAFETERIA	196,930	1,236	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	402,396	1,931	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,756	0	0	0	0	14.00
15.00	01500	PHARMACY	887,064	968	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	582,814	8,582	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,405,727	5,571	21,553	3,120	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	883,539	2,287	16,818	2,080	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,580,373	3,341	9,991	1,040	0	54.00
60.00	06000	LABORATORY	1,074,395	1,297	0	520	0	60.00
65.00	06500	RESPIRATORY THERAPY	255,876	1,564	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	565,343	3,354	3,862	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,067	0	922	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	76,889	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	210,188	0	1,859	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,240	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,193	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,287,466	4,589	34,067	3,120	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,548,303	39,649	90,484	9,880	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,088	212	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	131,870	0	2,624	1,040	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	440	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	1,318	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	88,915	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	227,040	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,559,145	1,532,086	152,331	546,108	338,537	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.350704	38.435714	1.636068	50.009890	3,385.370000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	660,830	224,413	30,562	34,698	43,325	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.050833	5.629889	0.328242	3.177473	433.250000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 12:49 pm

		Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	6,431					11.00
13.00	01300	NURSING ADMINISTRATION	382	3,583				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	100			14.00
15.00	01500	PHARMACY	0	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	624	0	0	0	55,372,885	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,559	1,557	0	0	2,599,415	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	710	710	0	0	5,797,669	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,240	0	0	0	17,942,349	54.00
60.00	06000	LABORATORY	100	0	0	0	9,187,127	60.00
65.00	06500	RESPIRATORY THERAPY	299	0	0	0	1,390,060	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,501,473	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	731,883	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	190,353	68.00
69.00	06900	ELECTROCARDIOLOGY	201	0	0	0	2,247,465	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,316	1,316	0	0	12,785,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,431	3,583	100	1,000	55,372,885	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	19302	PUBLIC RELATIONS	0	0	0	0	0	193.02
193.03	19303	FOUNDATION	0	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	0	0	0	0	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
193.06	19306	ENTERTAINMENT	0	0	0	0	0	193.06
193.07	19307	MARKETING	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	313,501	636,359	50,997	1,235,367	1,147,486	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.748406	177.605080	509.970000	1,235.367000	0.020723	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,148	52,082	1,919	60,079	165,322	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.532421	14.535864	19.190000	60.079000	0.002986	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 12:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,049,074		3,049,074	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,693,694		1,693,694	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,763,647		2,763,647	0	0	54.00
60.00	06000	LABORATORY	1,722,306		1,722,306	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	449,108	0	449,108	0	0	65.00
66.00	06600	PHYSICAL THERAPY	950,680	0	950,680	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	211,267	0	211,267	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	107,799	0	107,799	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	343,315		343,315	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,027		158,027	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	159,644		159,644	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,235,367		1,235,367	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,040,667		4,040,667	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	640,170		640,170	0	0	92.00
200.00		Subtotal (see instructions)	17,524,765	0	17,524,765	0	0	200.00
201.00		Less Observation Beds	640,170		640,170		0	201.00
202.00		Total (see instructions)	16,884,595	0	16,884,595	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 12:49 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	1,946,565		1,946,565			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	414,745	5,382,924	5,797,669	0.292134	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	669,577	17,272,771	17,942,348	0.154029	0.000000	54.00
60.00	06000	LABORATORY	930,939	8,256,188	9,187,127	0.187469	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	968,395	421,665	1,390,060	0.323085	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	269,051	2,232,422	2,501,473	0.380048	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,253	575,630	731,883	0.288662	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,232	174,120	190,352	0.566314	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	253,553	1,993,912	2,247,465	0.152757	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	352,770	805,883	1,158,653	0.136389	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	153,219	275,391	428,610	0.372469	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	986,671	3,062,932	4,049,603	0.305059	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	262,333	12,522,758	12,785,091	0.316045	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	20,391	632,459	652,850	0.980577	0.000000	92.00
200.00		Subtotal (see instructions)	7,400,694	53,609,055	61,009,749			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,400,694	53,609,055	61,009,749			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 12:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 12:49 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,049,074		3,049,074	0	3,049,074	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,693,694		1,693,694	0	1,693,694	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,763,647		2,763,647	0	2,763,647	54.00
60.00	06000	LABORATORY	1,722,306		1,722,306	0	1,722,306	60.00
65.00	06500	RESPIRATORY THERAPY	449,108	0	449,108	0	449,108	65.00
66.00	06600	PHYSICAL THERAPY	950,680	0	950,680	0	950,680	66.00
67.00	06700	OCCUPATIONAL THERAPY	211,267	0	211,267	0	211,267	67.00
68.00	06800	SPEECH PATHOLOGY	107,799	0	107,799	0	107,799	68.00
69.00	06900	ELECTROCARDIOLOGY	343,315		343,315	0	343,315	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,027		158,027	0	158,027	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	159,644		159,644	0	159,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,235,367		1,235,367	0	1,235,367	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,040,667		4,040,667	0	4,040,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	640,170		640,170		640,170	92.00
200.00		Subtotal (see instructions)	17,524,765	0	17,524,765	0	17,524,765	200.00
201.00		Less Observation Beds	640,170		640,170		640,170	201.00
202.00		Total (see instructions)	16,884,595	0	16,884,595	0	16,884,595	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 12:49 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	1,946,565		1,946,565			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	414,745	5,382,924	5,797,669	0.292134	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	669,577	17,272,771	17,942,348	0.154029	0.000000	54.00
60.00	06000	LABORATORY	930,939	8,256,188	9,187,127	0.187469	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	968,395	421,665	1,390,060	0.323085	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	269,051	2,232,422	2,501,473	0.380048	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,253	575,630	731,883	0.288662	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,232	174,120	190,352	0.566314	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	253,553	1,993,912	2,247,465	0.152757	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	352,770	805,883	1,158,653	0.136389	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	153,219	275,391	428,610	0.372469	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	986,671	3,062,932	4,049,603	0.305059	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	262,333	12,522,758	12,785,091	0.316045	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	20,391	632,459	652,850	0.980577	0.000000	92.00
200.00		Subtotal (see instructions)	7,400,694	53,609,055	61,009,749			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,400,694	53,609,055	61,009,749			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 12:49 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/27/2017 12:49 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	123,301	5,797,669	0.021267	181,964	3,870	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,036	17,942,348	0.010870	209,717	2,280	54.00
60.00	06000	LABORATORY	104,234	9,187,127	0.011346	369,715	4,195	60.00
65.00	06500	RESPIRATORY THERAPY	42,727	1,390,060	0.030738	453,512	13,940	65.00
66.00	06600	PHYSICAL THERAPY	84,083	2,501,473	0.033613	57,977	1,949	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,811	731,883	0.013405	20,941	281	67.00
68.00	06800	SPEECH PATHOLOGY	4,476	190,352	0.023514	6,652	156	68.00
69.00	06900	ELECTROCARDIOLOGY	18,916	2,247,465	0.008417	124,710	1,050	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,947	1,158,653	0.005133	160,578	824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,008	428,610	0.014017	65,771	922	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,079	4,049,603	0.014836	380,733	5,649	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	271,700	12,785,091	0.021251	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	53,640	652,850	0.082163	0	0	92.00
200.00		Total (lines 50-199)	979,958	59,063,184		2,032,270	35,116	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 12:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 12:49 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	5,797,669	0.000000	0.000000	181,964	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,942,348	0.000000	0.000000	209,717	54.00
60.00	06000	LABORATORY	0	9,187,127	0.000000	0.000000	369,715	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,390,060	0.000000	0.000000	453,512	65.00
66.00	06600	PHYSICAL THERAPY	0	2,501,473	0.000000	0.000000	57,977	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	731,883	0.000000	0.000000	20,941	67.00
68.00	06800	SPEECH PATHOLOGY	0	190,352	0.000000	0.000000	6,652	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,247,465	0.000000	0.000000	124,710	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,158,653	0.000000	0.000000	160,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	428,610	0.000000	0.000000	65,771	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,049,603	0.000000	0.000000	380,733	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	12,785,091	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	652,850	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	59,063,184			2,032,270	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1309	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/27/2017 12:49 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 12:49 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	0.292134	0	1,918,798	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154029	0	5,545,251	0	0	54.00
60.00	06000	LABORATORY	0.187469	0	3,051,010	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.323085	0	123,782	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.380048	0	690,064	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288662	0	211,432	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.566314	0	14,004	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152757	0	384,832	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136389	0	306,860	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372469	0	123,265	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305059	0	1,600,885	6,827	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.316045	0	3,052,967	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980577	0	295,364	0	0	92.00
200.00		Subtotal (see instructions)		0	17,318,514	6,827	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	17,318,514	6,827	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 12:49 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	560,546	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	854,129	0		54.00
60.00	06000	LABORATORY	571,970	0		60.00
65.00	06500	RESPIRATORY THERAPY	39,992	0		65.00
66.00	06600	PHYSICAL THERAPY	262,257	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	61,032	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,931	0		68.00
69.00	06900	ELECTROCARDIOLOGY	58,786	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,852	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,912	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	488,364	2,083		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	964,875	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	289,627	0		92.00
200.00		Subtotal (see instructions)	4,247,273	2,083		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,247,273	2,083		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 12:49 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	0.292134	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154029	0	0	0	0	54.00
60.00	06000	LABORATORY	0.187469	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.323085	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.380048	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288662	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.566314	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152757	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	0.136389	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372469	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305059	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.316045	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980577	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: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 12:49 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 12:49 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)	1,937	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,413	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,009	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	255	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)	255	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	7	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	577	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)	255	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)	217	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	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,049,074	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)	961	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)	961	25.00
26.00	Total swing-bed cost (see instructions)	810,058	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,239,016	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,239,016	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)	1,584.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	914,303	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)	914,303	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 12:49 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)	514,734	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,429,037	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)	404,068	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	343,854	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	747,922	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)	404	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,584.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	640,170	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 12:49 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	255,484	3,049,074	0.083791	640,170	53,640	90.00
91.00	Nursing School cost	0	3,049,074	0.000000	640,170	0	91.00
92.00	Allied health cost	0	3,049,074	0.000000	640,170	0	92.00
93.00	All other Medical Education	0	3,049,074	0.000000	640,170	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 12:49 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)	1,937	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,413	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,009	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	255	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)	255	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	7	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8	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	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,049,074	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)	961	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)	961	25.00
26.00	Total swing-bed cost (see instructions)	810,058	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,239,016	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,239,016	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)	1,584.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	12,677	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)	12,677	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 12:49 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)	301,854	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	314,531	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)	404	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,584.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	640,170	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 12:49 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	255,484	3,049,074	0.083791	640,170	53,640	90.00
91.00	Nursing School cost	0	3,049,074	0.000000	640,170	0	91.00
92.00	Allied health cost	0	3,049,074	0.000000	640,170	0	92.00
93.00	All other Medical Education	0	3,049,074	0.000000	640,170	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/27/2017 12:49 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		890,434		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.292134	181,964	53,158	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154029	209,717	32,302	54.00
60.00	06000	LABORATORY	0.187469	369,715	69,310	60.00
65.00	06500	RESPIRATORY THERAPY	0.323085	453,512	146,523	65.00
66.00	06600	PHYSICAL THERAPY	0.380048	57,977	22,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288662	20,941	6,045	67.00
68.00	06800	SPEECH PATHOLOGY	0.566314	6,652	3,767	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152757	124,710	19,050	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136389	160,578	21,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372469	65,771	24,498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305059	380,733	116,146	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.316045	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980577	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,032,270	514,734	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,032,270		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/27/2017 12:49 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	0.292134	589	172	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154029	33,656	5,184	54.00
60.00	06000	LABORATORY	0.187469	131,982	24,743	60.00
65.00	06500	RESPIRATORY THERAPY	0.323085	176,984	57,181	65.00
66.00	06600	PHYSICAL THERAPY	0.380048	152,303	57,882	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288662	114,244	32,978	67.00
68.00	06800	SPEECH PATHOLOGY	0.566314	7,251	4,106	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152757	6,783	1,036	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136389	60,886	8,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372469	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305059	157,108	47,927	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.316045	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980577	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		841,786	239,513	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)		841,786		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/27/2017 12:49 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		313,887		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.292134	141,989	41,480	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154029	221,520	34,121	54.00
60.00	06000	LABORATORY	0.187469	210,727	39,505	60.00
65.00	06500	RESPIRATORY THERAPY	0.323085	112,334	36,293	65.00
66.00	06600	PHYSICAL THERAPY	0.380048	13,546	5,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288662	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.566314	884	501	68.00
69.00	06900	ELECTROCARDIOLOGY	0.152757	37,446	5,720	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136389	92,046	12,554	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372469	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305059	227,918	69,528	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.316045	140,650	44,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.980577	12,801	12,552	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,211,861	301,854	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,211,861		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/27/2017 12:49 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,249,356	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)	4,249,356	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)	4,291,850	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)	61,712	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,856,860	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)	1,373,278	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)	1,373,278	30.00
31.00	Primary payer payments	538	31.00
32.00	Subtotal (line 30 minus line 31)	1,372,740	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)	635,323	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	412,960	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	365,090	36.00
37.00	Subtotal (see instructions)	1,785,700	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,785,700	40.00
40.01	Sequestration adjustment (see instructions)	35,714	40.01
41.00	Interim payments	1,714,294	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	35,692	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/27/2017 12:49 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		980,051		1,642,594	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	12/21/2016	84,900	12/21/2016	71,700	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		84,900		71,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,064,951		1,714,294	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		190,913		35,692	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,255,864		1,749,986	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/27/2017 12:49 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		766,986		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	12/21/2016	97,200		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		97,200		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)		864,186		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		113,722		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		977,908		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: 15-1309 | Component CCN: 15-Z309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-2 | Date/Time Prepared: 11/27/2017 12:49 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)	755,401	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)	241,908	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	472	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)	997,309	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	997,309	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)	997,309	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	161	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)	997,148	0	15.00
16.00		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	1,103	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	717	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	997,865	0	19.00
19.01	Sequestration adjustment (see instructions)	19,957	0	19.01
20.00	Interim payments	864,186	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)	113,722	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/27/2017 12:49 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,429,037	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,429,037	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,443,327	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,443,327	19.00
20.00	Deductibles (exclude professional component)	186,228	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,257,099	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,257,099	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,530	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	24,395	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,309	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,281,494	28.00
29.00		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,281,494	30.00
30.01	Sequestration adjustment (see instructions)	25,630	30.01
31.00	Interim payments	1,064,951	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	190,913	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: 15-1309	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/27/2017 12:49 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	314,531		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)	314,531	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)	314,531	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	313,887		8.00
9.00	Ancillary service charges	1,211,861	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,525,748	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,525,748	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,211,217	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)	314,531	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)	314,531	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)	314,531	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)	314,531	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	314,531	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)	314,531	0	40.00
41.00	Interim payments	314,531	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: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/27/2017 12:49 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,244,745	0	0	0	1.00
2.00	Temporary investments	159,286	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,008,684	0	0	0	4.00
5.00	Other receivable	859,112	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,605,497	0	0	0	6.00
7.00	Inventory	411,077	0	0	0	7.00
8.00	Prepaid expenses	226,399	0	0	0	8.00
9.00	Other current assets	-243,344	0	0	0	9.00
10.00	Due from other funds	306,729	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,367,191	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,500	0	0	0	12.00
13.00	Land improvements	192,578	0	0	0	13.00
14.00	Accumulated depreciation	-190,475	0	0	0	14.00
15.00	Buildings	9,334,448	0	0	0	15.00
16.00	Accumulated depreciation	-4,181,315	0	0	0	16.00
17.00	Leasehold improvements	995,040	0	0	0	17.00
18.00	Accumulated depreciation	-517,007	0	0	0	18.00
19.00	Fixed equipment	2,979,232	0	0	0	19.00
20.00	Accumulated depreciation	-2,437,855	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,169,759	0	0	0	23.00
24.00	Accumulated depreciation	-6,164,198	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,182,707	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	41,623	1,888,828	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	41,623	1,888,828	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	12,591,521	1,888,828	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	750,093	0	0	0	37.00
38.00	Salaries, wages, and fees payable	979,354	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	100,744	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,321,290	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,151,481	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,472,662	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	105,723	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,578,385	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,729,866	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	861,655				52.00
53.00	Specific purpose fund		1,888,828			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)	861,655	1,888,828	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	12,591,521	1,888,828	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/27/2017 12:49 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		36,173,221		1,749,934		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		944,892				2.00
3.00	Total (sum of line 1 and line 2)		37,118,113		1,749,934		3.00
4.00	PENSION COST ADJUSTMENT	-183,073		0		0	4.00
5.00	CONTRIBUTIONS	0		70,785		0	5.00
6.00	RESTRICTED INVEST. INCOME - HSD	0		73,270		0	6.00
7.00	RESTRICTED INVEST. INCOME NON-HSD	0		-7,974		0	7.00
8.00	TRANSFER FROM AFFLIATES	-36,073,385		0		0	8.00
9.00	ROUNDING	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-36,256,458		136,081		10.00
11.00	Subtotal (line 3 plus line 10)		861,655		1,886,015		11.00
12.00	TRANSFER FROM AFFILIATES	0		59,741		0	12.00
13.00	UNREALIZED LOSSES- RESTRICTED HSD	0		-40,040		0	13.00
14.00	UNREALIZED LOSSES RESTRICTED NON-HSD	0		-22,514		0	14.00
15.00	ROUNDING	0		0		0	15.00
16.00	PENSION COST ADJUSTMENT	0		0		0	16.00
17.00	ROUNDING	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		-2,813		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		861,655		1,888,828		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	PENSION COST ADJUSTMENT		0			4.00
5.00	CONTRIBUTIONS		0			5.00
6.00	RESTRICTED INVEST. INCOME - HSD		0			6.00
7.00	RESTRICTED INVEST. INCOME NON-HSD		0			7.00
8.00	TRANSFER FROM AFFLIATES		0			8.00
9.00	ROUNDING		0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFER FROM AFFILIATES		0			12.00
13.00	UNREALIZED LOSSES- RESTRICTED HSD		0			13.00
14.00	UNREALIZED LOSSES RESTRICTED NON-HSD		0			14.00
15.00	ROUNDING		0			15.00
16.00	PENSION COST ADJUSTMENT		0			16.00
17.00	ROUNDING		0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1309 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/27/2017 12:49 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,472,303		2,472,303	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)	2,472,303		2,472,303	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)	2,472,303		2,472,303	17.00
18.00	Ancillary services	5,166,808	39,950,223	45,117,031	18.00
19.00	Outpatient services	282,724	13,137,690	13,420,414	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,921,835	53,087,913	61,009,748	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,330,031		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)		18,330,031		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1309	Period: From 07/01/2016 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/27/2017 12:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	61,009,748	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,927,423	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,082,325	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,330,031	4.00
5.00	Net income from service to patients (line 3 minus line 4)	752,294	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-1,406	6.00
7.00	Income from investments	514	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	32,017	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	1,929	17.00
18.00	Revenue from sale of medical records and abstracts	828	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	132,168	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC. INCOME	8,292	24.00
24.01	ASSETS RELEASED FROM RESTRICTION	33,595	24.01
24.02		0	24.02
24.03	UNREALIZED LOSS	0	24.03
24.04		0	24.04
24.05		0	24.05
25.00	Total other income (sum of lines 6-24)	207,937	25.00
26.00	Total (line 5 plus line 25)	960,231	26.00
27.00		0	27.00
27.01	FUNDRAISING EXPENSES	15,339	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	15,339	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	944,892	29.00