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: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet S Parts I-III Date/Time Prepared: 11/13/2017 1:28 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/13/2017 Time: 1:28 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 FRANKFORT HOSPITAL (15-1316) for the cost reporting period beginning 07/01/2016 and ending 05/31/2017 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	768,569	611,308	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	321,776	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	1,090,345	611,308	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/13/2017 1:27 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 SOUTH JACKSON STREET	PO Box:			1.00
2.00	City: FRANKFORT	State: IN	Zip Code: 46041	County: CLINTON	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 FRANKFORT HOSPITAL	151316	99915	1	01/21/2003	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 FRANKFORT HOSPITAL	15Z316	99915		01/21/2003	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	05/31/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/13/2017 1:27 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/13/2017 1:27 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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/13/2017 1:27 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.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/13/2017 1:27 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	71,324	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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/13/2017 1:27 pm

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet S-2 Part I Date/Time Prepared: 11/13/2017 1:27 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)	10/01/2015	09/30/2016	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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/13/2017 1:27 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)	N			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/02/2017	Y	10/02/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/13/2017 1:27 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: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet S-2 Part II Date/Time Prepared: 11/13/2017 1:27 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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/13/2017 1:27 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	8,375	22,512.00	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	8,375	22,512.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	8,375	22,512.00	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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/13/2017 1:27 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)	526	10	938			1.00
2.00	HMO and other (see instructions)	101	196				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	199	0	233			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	10			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	725	10	1,181			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		74	186			13.00
14.00	Total (see instructions)	725	84	1,367	0.00	93.44	14.00
15.00	CAH visits	7,423	731	27,114			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	93.44	27.00
28.00	Observation Bed Days		0	324			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	32	32			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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/13/2017 1:27 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	154	16	328	1.00
2.00	HMO and other (see instructions)			28	79		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	154	16	328	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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet S-10 | Date/Time Prepared: 11/13/2017 1:27 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)	0.328531	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,154,093	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	18,651,292	6.00
7.00	Medicaid cost (line 1 times line 6)	6,127,528	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)	3,973,435	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)	3,973,435	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)	3,757,875	792,543	4,550,418	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,234,578	792,543	2,027,121	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,234,578	792,543	2,027,121	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)	1,395,345	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	499,468	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	768,412	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	626,933	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	474,911	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,502,032	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,475,467	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A | Date/Time Prepared: 11/13/2017 1:27 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		859,763	859,763	-229	859,534	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		596,983	596,983	0	596,983	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-65,496	1,667,921	1,602,425	0	1,602,425	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,437,038	3,105,071	4,542,109	229	4,542,338	5.00
7.00	00700	OPERATION OF PLANT	0	3,390,000	3,390,000	0	3,390,000	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	38,337	38,337	0	38,337	8.00
9.00	00900	HOUSEKEEPING	0	405,951	405,951	0	405,951	9.00
10.00	01000	DIETARY	0	394,021	394,021	-312,043	81,978	10.00
11.00	01100	CAFETERIA	0	0	0	312,043	312,043	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	519,383	14,250	533,633	0	533,633	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,679	6,367	66,046	0	66,046	14.00
15.00	01500	PHARMACY	302,590	360,679	663,269	0	663,269	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	254,223	111,761	365,984	0	365,984	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,199,336	376,866	1,576,202	-628,509	947,693	30.00
43.00	04300	NURSERY	0	0	0	148,840	148,840	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	379,921	269,636	649,557	-17,000	632,557	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	478,498	478,498	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	579,572	350,834	930,406	0	930,406	54.00
60.00	06000	LABORATORY	0	1,071,971	1,071,971	-77	1,071,894	60.00
65.00	06500	RESPIRATORY THERAPY	140,682	93,539	234,221	0	234,221	65.00
66.00	06600	PHYSICAL THERAPY	1,021	594,978	595,999	-176,306	419,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	176,306	176,306	67.00
68.00	06800	SPEECH PATHOLOGY	77,859	33	77,892	0	77,892	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	190	190	18,504	18,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,894	9,894	0	9,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	897,293	1,713,116	2,610,409	-256	2,610,153	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,783,101	15,432,161	21,215,262	0	21,215,262	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	87	87	0	87	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	210,055	210,055	0	210,055	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	5,783,101	15,642,303	21,425,404	0	21,425,404	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A | Date/Time Prepared: 11/13/2017 1:27 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	-16,392	843,142		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	596,983		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,240,448	2,842,873		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-978,570	3,563,768		5.00
7.00	00700	OPERATION OF PLANT	-15,500	3,374,500		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	38,337		8.00
9.00	00900	HOUSEKEEPING	0	405,951		9.00
10.00	01000	DIETARY	0	81,978		10.00
11.00	01100	CAFETERIA	-73,988	238,055		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	-6,722	526,911		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	66,046		14.00
15.00	01500	PHARMACY	-74	663,195		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,787	356,197		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	947,693		30.00
43.00	04300	NURSERY	0	148,840		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	632,557		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	478,498		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-46,102	884,304		54.00
60.00	06000	LABORATORY	0	1,071,894		60.00
65.00	06500	RESPIRATORY THERAPY	0	234,221		65.00
66.00	06600	PHYSICAL THERAPY	0	419,693		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	176,306		67.00
68.00	06800	SPEECH PATHOLOGY	0	77,892		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,694		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,894		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,610,153		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	93,313	21,308,575		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	87		194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	110,918	320,973		194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	204,231	21,629,635		200.00

RECLASSIFICATIONS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-6 | Date/Time Prepared: 11/13/2017 1:27 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	0	312,043	1.00
	TOTALS		0	312,043	
	B - NURSEY AND L&D RECLASS				
1.00	NURSERY	43.00	98,408	50,432	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	316,367	162,131	2.00
	TOTALS		414,775	212,563	
	C - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	229	1.00
	TOTALS		0	229	
	D - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	18,504	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	18,504	
	E - THERAPIES RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	302	176,004	1.00
	TOTALS		302	176,004	
500.00	Grand Total: Increases		415,077	719,343	500.00

RECLASSIFICATIONS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-6 | Date/Time Prepared: 11/13/2017 1:27 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA RECLASS					
1.00	DIETARY	10.00	0	312,043	0	1.00
	TOTALS		0	312,043		
	B - NURSEY AND L&D RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	414,775	212,563	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		414,775	212,563		
	C - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	229	9	1.00
	TOTALS		0	229		
	D - MEDICAL SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	1,171	0	1.00
2.00	OPERATING ROOM	50.00	0	17,000	0	2.00
3.00	LABORATORY	60.00	0	77	0	3.00
4.00	EMERGENCY	91.00	0	256	0	4.00
	TOTALS		0	18,504		
	E - THERAPIES RECLASS					
1.00	PHYSICAL THERAPY	66.00	302	176,004	0	1.00
	TOTALS		302	176,004		
500.00	Grand Total: Decreases		415,077	719,343		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/13/2017 1:27 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	160,146	0	0	0	0	1.00
2.00	Land Improvements	66,241	0	0	0	65,771	2.00
3.00	Buildings and Fixtures	2,078,615	1,353,924	0	1,353,924	0	3.00
4.00	Building Improvements	0	957,736	0	957,736	0	4.00
5.00	Fixed Equipment	834,970	0	0	0	150,388	5.00
6.00	Movable Equipment	4,876,508	0	0	0	9,877,990	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,016,480	2,311,660	0	2,311,660	10,094,149	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,016,480	2,311,660	0	2,311,660	10,094,149	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	160,146	0	1.00
2.00	Land Improvements	470	0	2.00
3.00	Buildings and Fixtures	3,432,539	0	3.00
4.00	Building Improvements	957,736	0	4.00
5.00	Fixed Equipment	684,582	0	5.00
6.00	Movable Equipment	-5,001,482	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	233,991	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	233,991	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/13/2017 1:27 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	140,423	687,500	16,621	2,668	12,551	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	291,786	304,879	0	318	0	2.00
3.00	Total (sum of lines 1-2)	432,209	992,379	16,621	2,986	12,551	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	859,763		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	596,983		2.00
3.00	Total (sum of lines 1-2)	0	1,456,746		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/13/2017 1:27 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	5,235,473	0	5,235,473	22.374677	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-5,001,482	0	-5,001,482	-21.374677	0	2.00
3.00	Total (sum of lines 1-2)	233,991	0	233,991	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	140,194	687,500	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	291,786	304,879	2.00
3.00	Total (sum of lines 1-2)	0	0	0	431,980	992,379	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	229	2,668	12,551	0	843,142	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	318	0	0	596,983	2.00
3.00	Total (sum of lines 1-2)	229	2,986	12,551	0	1,440,125	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-8 | Date/Time Prepared: 11/13/2017 1:27 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	-16,304	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-228	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	-68,387			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,018,537			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-73,988	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9,787	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-6,538	NURSING ADMINISTRATION	13.00	0	33.00
33.01	MISC INCOME	B	-74	PHARMACY	15.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-8 | Date/Time Prepared: 11/13/2017 1:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	NON-ALLOWABLE EXPENSE	A	-47	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PROVIDER TAX ADJUSTMENT	A	-649,838	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.05	NON-ALLOWABLE EXPENSE	A	-184	NURSING ADMINISTRATION	13.00	0	33.05
33.08	LOBBYING	A	-851	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.11	PHYSICIAN SUPPORT SERVICES	A	-240	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.13	INCENTIVE ACCRUAL ADJUSTMENT	A	12,160	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		204,231				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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/13/2017 1:27 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	121,852	121,852	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,264,702	1,592,067	2.00
3.00	194.02	OTHER NONREIMBURSABLE - MARK	HOME OFFICE	110,918	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	308,576	308,576	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	1,417,003	1,417,003	4.01
4.02	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	68,557	68,557	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	SVH CHARGEBACKS	63,446	63,446	4.03
4.04	15.00	PHARMACY	SVH CHARGEBACKS	30,513	30,513	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACKS	364,125	364,125	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	32,312	32,312	4.06
4.08	65.00	RESPIRATORY THERAPY	SVH CHARGEBACKS	68,690	68,690	4.08
4.09	91.00	EMERGENCY	SVH CHARGEBACKS	175	175	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF INSURANCE	1,805,585	765,385	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	16,304	16,392	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	228	229	4.12
4.13	7.00	OPERATION OF PLANT	MEDXCEL	2,127,885	2,143,385	4.13
4.23	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	207,339	-3,034	4.23
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,008,210	6,989,673	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		0.00	ST. VINCENT HEA	100.00	6.00
7.00	B		0.00	ST. VINCENT HOS	100.00	7.00
8.00	G		0.00	ASCENSION	100.00	8.00
9.00	A		0.00	TRIMEDX	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/13/2017 1:27 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	-327,365	0		2.00
3.00	110,918	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.08	0	0		4.08
4.09	0	0		4.09
4.10	1,040,200	0		4.10
4.11	-88	11		4.11
4.12	-1	0		4.12
4.13	-15,500	0		4.13
4.23	210,373	0		4.23
5.00	1,018,537			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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/13/2017 1:27 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	22,285	22,285	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	46,102	46,102	0	0	0	2.00
3.00	91.00	EMERGENCY	1,597,147	0	1,597,147	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			1,665,534	68,387	1,597,147		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	4.00	EMPLOYEE BENEFITS DEPARTMENT	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	22,285		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	46,102		2.00
3.00	91.00	EMERGENCY	0	0	0	0		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	68,387		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/13/2017 1:27 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)					261	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					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	4,427.00	1,478.00	1,279.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.26	52.82	25.58	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)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					359,738	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					78,068	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					437,806	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					32,717	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)					470,523	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)					470,523	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)					10,604	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)					10,604	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)					1,670	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					12,274	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)					12,274	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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/13/2017 1:27 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	25.58	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)	470,523	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	12,274	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)	482,797	63.00
64.00	Total cost of outside supplier services (from your records)	418,974	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	10,604	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,670	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	12,274	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	1,670	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	1,670	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: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/13/2017 1:27 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)		184	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	1,304.00	1,552.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.03	53.15	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	26.58			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)	100,447	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	82,489	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	182,936	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)	182,936	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)	182,936	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)	7,088	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)	7,088	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)	1,178	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	8,266	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)	8,266	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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/13/2017 1:27 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	53.15	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)	182,936	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,266	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)	191,202	63.00
64.00	Total cost of outside supplier services (from your records)	176,004	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	7,088	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,178	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,266	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	1,178	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	1,178	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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B Part I Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	843,142	843,142				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	596,983		596,983			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,842,873	8,724	8,374	2,859,971		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,563,768	78,809	75,649	702,713	4,420,939	5.00
7.00	00700	OPERATION OF PLANT	3,374,500	86,637	83,164	0	3,544,301	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,337	6,580	6,316	0	51,233	8.00
9.00	00900	HOUSEKEEPING	405,951	15,309	14,695	0	435,955	9.00
10.00	01000	DIETARY	81,978	20,835	20,000	0	122,813	10.00
11.00	01100	CAFETERIA	238,055	9,798	9,406	0	257,259	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	526,911	19,444	18,665	253,979	818,999	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,046	28,184	27,054	29,183	150,467	14.00
15.00	01500	PHARMACY	663,195	14,513	13,931	147,967	839,606	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	356,197	16,436	15,777	124,315	512,725	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	947,693	130,636	125,396	383,651	1,587,376	30.00
43.00	04300	NURSERY	148,840	2,629	2,523	48,122	202,114	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	632,557	55,209	52,995	185,782	926,543	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	478,498	11,511	11,049	154,704	655,762	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	884,304	38,599	37,051	283,411	1,243,365	54.00
60.00	06000	LABORATORY	1,071,894	16,410	15,752	0	1,104,056	60.00
65.00	06500	RESPIRATORY THERAPY	234,221	8,123	7,798	68,794	318,936	65.00
66.00	06600	PHYSICAL THERAPY	419,693	16,326	15,671	352	452,042	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,306	985	946	148	178,385	67.00
68.00	06800	SPEECH PATHOLOGY	77,892	3,050	2,928	38,073	121,943	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,694	0	0	0	18,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,894	0	0	0	9,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,610,153	27,172	26,083	438,777	3,102,185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,308,575	615,919	591,223	2,859,971	21,075,592	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,855	2,741	0	5,596	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	87	3,145	3,019	0	6,251	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	320,973	0	0	0	320,973	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	221,223	0	0	221,223	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,629,635	843,142	596,983	2,859,971	21,629,635	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B Part I | Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,420,939					5.00
7.00	00700	OPERATION OF PLANT	910,542	4,454,843				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,162	43,816	108,211			8.00
9.00	00900	HOUSEKEEPING	111,997	101,945	0	649,897		9.00
10.00	01000	DIETARY	31,551	138,745	3,244	30,959	327,312	10.00
11.00	01100	CAFETERIA	66,090	65,250	0	14,560	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	210,402	129,483	0	28,892	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	38,655	187,682	1,079	41,879	0	14.00
15.00	01500	PHARMACY	215,696	96,648	0	21,566	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	131,720	109,452	0	24,423	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	407,798	869,934	38,956	194,114	327,312	30.00
43.00	04300	NURSERY	51,923	17,505	0	3,906	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	238,030	367,647	9,739	82,036	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	168,466	76,652	0	17,104	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319,422	257,037	0	57,354	0	54.00
60.00	06000	LABORATORY	283,633	109,277	0	24,384	0	60.00
65.00	06500	RESPIRATORY THERAPY	81,935	54,095	0	12,070	0	65.00
66.00	06600	PHYSICAL THERAPY	116,130	108,715	19,416	24,258	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,827	6,560	5,472	1,464	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,327	20,312	0	4,532	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,803	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,542	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	796,954	180,947	16,235	40,376	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,278,605	2,941,702	94,141	623,877	327,312	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,438	19,014	0	4,243	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	14,070	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	1,606	20,943	0	4,673	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	82,458	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	56,832	1,473,184	0	17,104	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,420,939	4,454,843	108,211	649,897	327,312	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B Part I | Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	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
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	403,159					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	37,499	0	1,225,275			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,461	0	0	432,223		14.00
15.00	01500	PHARMACY	21,229	0	0	911	1,195,656	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,868	0	0	4	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,959	0	317,238	31,182	0	30.00
43.00	04300	NURSERY	8,276	0	33,677	5,589	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,692	0	141,171	116,591	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,609	0	108,279	17,969	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,489	0	209,526	12,236	0	54.00
60.00	06000	LABORATORY	0	0	0	458	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,452	0	50,672	16,635	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	23,254	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,721	0	23,279	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	416	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,886	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,195,656	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	83,904	0	341,433	186,092	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)	403,159	0	1,225,275	432,223	1,195,656	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	403,159	0	1,225,275	432,223	1,195,656	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B Part I Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	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
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	809,192					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,257	0	3,883,126	0	3,883,126	30.00
43.00	04300	NURSERY	4,496	0	327,486	0	327,486	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,379	0	1,967,828	0	1,967,828	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,453	0	1,085,294	0	1,085,294	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	199,738	0	2,350,167	0	2,350,167	54.00
60.00	06000	LABORATORY	126,634	0	1,648,442	0	1,648,442	60.00
65.00	06500	RESPIRATORY THERAPY	17,321	0	564,116	0	564,116	65.00
66.00	06600	PHYSICAL THERAPY	40,274	0	784,089	0	784,089	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,829	0	253,537	0	253,537	67.00
68.00	06800	SPEECH PATHOLOGY	4,736	0	211,850	0	211,850	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	23,913	0	23,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	33,322	0	33,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,195,656	0	1,195,656	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	303,075	0	5,051,201	0	5,051,201	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)	809,192	0	19,380,027	0	19,380,027	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	30,291	0	30,291	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	14,070	0	14,070	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	33,473	0	33,473	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	403,431	0	403,431	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	1,768,343	0	1,768,343	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	809,192	0	21,629,635	0	21,629,635	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,724	8,374	17,098	17,098	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	392,019	78,809	75,649	546,477	4,203	5.00
7.00	00700	OPERATION OF PLANT	0	86,637	83,164	169,801	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,580	6,316	12,896	0	8.00
9.00	00900	HOUSEKEEPING	0	15,309	14,695	30,004	0	9.00
10.00	01000	DIETARY	0	20,835	20,000	40,835	0	10.00
11.00	01100	CAFETERIA	0	9,798	9,406	19,204	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	19,444	18,665	38,109	1,518	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,184	27,054	55,238	174	14.00
15.00	01500	PHARMACY	0	14,513	13,931	28,444	884	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,436	15,777	32,213	743	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	130,636	125,396	256,032	2,293	30.00
43.00	04300	NURSERY	0	2,629	2,523	5,152	288	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	55,209	52,995	108,204	1,111	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,511	11,049	22,560	925	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,599	37,051	75,650	1,694	54.00
60.00	06000	LABORATORY	0	16,410	15,752	32,162	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,123	7,798	15,921	411	65.00
66.00	06600	PHYSICAL THERAPY	0	16,326	15,671	31,997	2	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	985	946	1,931	1	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,050	2,928	5,978	228	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	27,172	26,083	53,255	2,623	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)	392,019	615,919	591,223	1,599,161	17,098	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,855	2,741	5,596	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	3,145	3,019	6,164	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	221,223	0	221,223	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	392,019	843,142	596,983	1,832,144	17,098	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	550,680					5.00
7.00	00700	OPERATION OF PLANT	113,421	283,222				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,639	2,786	17,321			8.00
9.00	00900	HOUSEKEEPING	13,951	6,481	0	50,436		9.00
10.00	01000	DIETARY	3,930	8,821	519	2,403	56,508	10.00
11.00	01100	CAFETERIA	8,232	4,148	0	1,130	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	26,208	8,232	0	2,242	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,815	11,932	173	3,250	0	14.00
15.00	01500	PHARMACY	26,867	6,144	0	1,674	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,407	6,959	0	1,895	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,796	55,307	6,235	15,065	56,508	30.00
43.00	04300	NURSERY	6,468	1,113	0	303	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,649	23,374	1,559	6,366	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,984	4,873	0	1,327	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,788	16,341	0	4,451	0	54.00
60.00	06000	LABORATORY	35,330	6,947	0	1,892	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,206	3,439	0	937	0	65.00
66.00	06600	PHYSICAL THERAPY	14,465	6,912	3,108	1,883	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,708	417	876	114	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,902	1,291	0	352	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	598	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	317	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	99,270	11,504	2,599	3,133	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)	532,951	187,021	15,069	48,417	56,508	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	179	1,209	0	329	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	2,252	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	200	1,331	0	363	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	10,271	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	7,079	93,661	0	1,327	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	550,680	283,222	17,321	50,436	56,508	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	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
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	32,714					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	3,043	0	79,352			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,011	0	0	76,593		14.00
15.00	01500	PHARMACY	1,723	0	0	161	65,897	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,505	0	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,326	0	20,545	5,526	0	30.00
43.00	04300	NURSERY	672	0	2,181	990	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,815	0	9,143	20,661	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,159	0	7,012	3,184	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,178	0	13,569	2,168	0	54.00
60.00	06000	LABORATORY	0	0	0	81	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,010	0	3,282	2,948	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,121	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	464	0	1,508	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	74	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,701	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	65,897	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,808	0	22,112	32,977	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)	32,714	0	79,352	76,593	65,897	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	32,714	0	79,352	76,593	65,897	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	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
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	60,723					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,346	0	476,979	0	476,979	30.00
43.00	04300	NURSERY	337	0	17,504	0	17,504	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,857	0	206,739	0	206,739	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,085	0	64,109	0	64,109	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,994	0	172,833	0	172,833	54.00
60.00	06000	LABORATORY	9,506	0	85,918	0	85,918	60.00
65.00	06500	RESPIRATORY THERAPY	1,300	0	39,454	0	39,454	65.00
66.00	06600	PHYSICAL THERAPY	3,023	0	65,511	0	65,511	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,188	0	10,235	0	10,235	67.00
68.00	06800	SPEECH PATHOLOGY	356	0	14,079	0	14,079	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	672	0	672	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,018	0	4,018	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	65,897	0	65,897	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	22,731	0	257,012	0	257,012	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)	60,723	0	1,480,960	0	1,480,960	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	7,313	0	7,313	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	2,252	0	2,252	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	8,058	0	8,058	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	10,271	0	10,271	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	323,290	0	323,290	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	60,723	0	1,832,144	0	1,832,144	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	160,050					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		118,056				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,656	1,656	5,848,597			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,960	14,960	1,437,038	-4,420,939	17,208,696	5.00
7.00	00700	OPERATION OF PLANT	16,446	16,446	0	0	3,544,301	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,249	1,249	0	0	51,233	8.00
9.00	00900	HOUSEKEEPING	2,906	2,906	0	0	435,955	9.00
10.00	01000	DIETARY	3,955	3,955	0	0	122,813	10.00
11.00	01100	CAFETERIA	1,860	1,860	0	0	257,259	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,691	3,691	519,383	0	818,999	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,350	5,350	59,679	0	150,467	14.00
15.00	01500	PHARMACY	2,755	2,755	302,590	0	839,606	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,120	3,120	254,223	0	512,725	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,798	24,798	784,561	0	1,587,376	30.00
43.00	04300	NURSERY	499	499	98,408	0	202,114	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,480	10,480	379,921	0	926,543	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,185	2,185	316,367	0	655,762	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,327	7,327	579,572	0	1,243,365	54.00
60.00	06000	LABORATORY	3,115	3,115	0	0	1,104,056	60.00
65.00	06500	RESPIRATORY THERAPY	1,542	1,542	140,682	0	318,936	65.00
66.00	06600	PHYSICAL THERAPY	3,099	3,099	719	0	452,042	66.00
67.00	06700	OCCUPATIONAL THERAPY	187	187	302	0	178,385	67.00
68.00	06800	SPEECH PATHOLOGY	579	579	77,859	0	121,943	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	18,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,158	5,158	897,293	0	3,102,185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,917	116,917	5,848,597	-4,420,939	16,654,653	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	542	0	0	5,596	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	597	597	0	0	6,251	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	320,973	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	41,994	0	0	0	221,223	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	843,142	596,983	2,859,971		4,420,939	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.267991	5.056778	0.489001		0.256901	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			17,098		550,680	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002923		0.032000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	126,988					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,249	13,744				8.00
9.00	00900	HOUSEKEEPING	2,906	0	83,024			9.00
10.00	01000	DIETARY	3,955	412	3,955	4,313		10.00
11.00	01100	CAFETERIA	1,860	0	1,860	0	136,014	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,691	0	3,691	0	12,651	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,350	137	5,350	0	4,204	14.00
15.00	01500	PHARMACY	2,755	0	2,755	0	7,162	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,120	0	3,120	0	10,414	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,798	4,948	24,798	4,313	26,301	30.00
43.00	04300	NURSERY	499	0	499	0	2,792	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,480	1,237	10,480	0	11,704	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,185	0	2,185	0	8,977	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,327	0	7,327	0	17,371	54.00
60.00	06000	LABORATORY	3,115	0	3,115	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,542	0	1,542	0	4,201	65.00
66.00	06600	PHYSICAL THERAPY	3,099	2,466	3,099	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	187	695	187	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	579	0	579	0	1,930	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,158	2,062	5,158	0	28,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	83,855	11,957	79,700	4,313	136,014	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	0	542	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	1,787	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	597	0	597	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	41,994	0	2,185	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,454,843	108,211	649,897	327,312	403,159	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.080819	7.873327	7.827821	75.889636	2.964099	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	283,222	17,321	50,436	56,508	32,714	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.230305	1.260259	0.607487	13.101785	0.240519	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			12.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	101,583				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	197,359			14.00
15.00	01500	PHARMACY	0	0	416	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2	0	55,020,404	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	26,301	14,238	0	2,125,317	30.00
43.00	04300	NURSERY	0	2,792	2,552	0	305,682	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,704	53,237	0	3,493,474	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,977	8,205	0	982,719	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,371	5,587	0	13,581,180	54.00
60.00	06000	LABORATORY	0	0	209	0	8,610,489	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,201	7,596	0	1,177,709	65.00
66.00	06600	PHYSICAL THERAPY	0	0	10,618	0	2,738,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,076,262	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,930	0	0	322,023	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	190	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,537	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	0	28,307	84,972	0	20,607,105	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	101,583	197,359	1,000	55,020,404	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,225,275	432,223	1,195,656	809,192	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	12.061812	2.190034	1,195.656000	0.014707	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	79,352	76,593	65,897	60,723	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.781154	0.388090	65.897000	0.001104	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 11/13/2017 1:27 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	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)	0		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0		194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0		194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0		194.03
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet C Part I Date/Time Prepared: 11/13/2017 1:27 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	3,883,126		3,883,126	0	0	30.00
43.00	04300	NURSERY	327,486		327,486	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,967,828		1,967,828	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,085,294		1,085,294	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,350,167		2,350,167	0	0	54.00
60.00	06000	LABORATORY	1,648,442		1,648,442	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	564,116	0	564,116	0	0	65.00
66.00	06600	PHYSICAL THERAPY	784,089	0	784,089	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	253,537	0	253,537	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	211,850	0	211,850	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,913		23,913	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,322		33,322	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,195,656		1,195,656	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,051,201		5,051,201	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	841,263		841,263		0	92.00
200.00		Subtotal (see instructions)	20,221,290	0	20,221,290	0	0	200.00
201.00		Less Observation Beds	841,263		841,263		0	201.00
202.00		Total (see instructions)	19,380,027	0	19,380,027	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet C Part I Date/Time Prepared: 11/13/2017 1:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,705,565		1,705,565			30.00
43.00	04300	NURSERY	305,682		305,682			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	278,803	3,214,671	3,493,474	0.563287	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	635,902	346,817	982,719	1.104379	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	334,186	13,246,994	13,581,180	0.173046	0.000000	54.00
60.00	06000	LABORATORY	443,330	8,167,159	8,610,489	0.191446	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	336,715	840,994	1,177,709	0.478994	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	270,582	2,467,862	2,738,444	0.286326	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	289,104	787,158	1,076,262	0.235572	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	60,328	261,695	322,023	0.657872	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,992	453,312	704,304	0.033953	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,517	8,887	10,404	3.202807	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,257,210	1,997,660	3,254,870	0.367344	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	196,145	20,410,960	20,607,105	0.245119	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,697	403,055	419,752	2.004191	0.000000	92.00
200.00		Subtotal (see instructions)	6,382,758	52,607,224	58,989,982			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,382,758	52,607,224	58,989,982			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet C Part I Date/Time Prepared: 11/13/2017 1:27 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet C Part I Date/Time Prepared: 11/13/2017 1:27 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	3,883,126		3,883,126	0	3,883,126	30.00
43.00	04300	NURSERY	327,486		327,486	0	327,486	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,967,828		1,967,828	0	1,967,828	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,085,294		1,085,294	0	1,085,294	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,350,167		2,350,167	0	2,350,167	54.00
60.00	06000	LABORATORY	1,648,442		1,648,442	0	1,648,442	60.00
65.00	06500	RESPIRATORY THERAPY	564,116	0	564,116	0	564,116	65.00
66.00	06600	PHYSICAL THERAPY	784,089	0	784,089	0	784,089	66.00
67.00	06700	OCCUPATIONAL THERAPY	253,537	0	253,537	0	253,537	67.00
68.00	06800	SPEECH PATHOLOGY	211,850	0	211,850	0	211,850	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,913		23,913	0	23,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,322		33,322	0	33,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,195,656		1,195,656	0	1,195,656	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,051,201		5,051,201	0	5,051,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	841,263		841,263		841,263	92.00
200.00		Subtotal (see instructions)	20,221,290	0	20,221,290	0	20,221,290	200.00
201.00		Less Observation Beds	841,263		841,263		841,263	201.00
202.00		Total (see instructions)	19,380,027	0	19,380,027	0	19,380,027	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet C Part I Date/Time Prepared: 11/13/2017 1:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,705,565		1,705,565			30.00
43.00	04300	NURSERY	305,682		305,682			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	278,803	3,214,671	3,493,474	0.563287	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	635,902	346,817	982,719	1.104379	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	334,186	13,246,994	13,581,180	0.173046	0.000000	54.00
60.00	06000	LABORATORY	443,330	8,167,159	8,610,489	0.191446	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	336,715	840,994	1,177,709	0.478994	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	270,582	2,467,862	2,738,444	0.286326	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	289,104	787,158	1,076,262	0.235572	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	60,328	261,695	322,023	0.657872	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,992	453,312	704,304	0.033953	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,517	8,887	10,404	3.202807	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,257,210	1,997,660	3,254,870	0.367344	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	196,145	20,410,960	20,607,105	0.245119	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,697	403,055	419,752	2.004191	0.000000	92.00
200.00		Subtotal (see instructions)	6,382,758	52,607,224	58,989,982			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,382,758	52,607,224	58,989,982			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet C Part I Date/Time Prepared: 11/13/2017 1:27 pm
	Title XIX	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part II Date/Time Prepared: 11/13/2017 1:27 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	206,739	3,493,474	0.059179	53,328	3,156	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,109	982,719	0.065236	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,833	13,581,180	0.012726	142,527	1,814	54.00
60.00	06000	LABORATORY	85,918	8,610,489	0.009978	146,876	1,466	60.00
65.00	06500	RESPIRATORY THERAPY	39,454	1,177,709	0.033501	264,424	8,858	65.00
66.00	06600	PHYSICAL THERAPY	65,511	2,738,444	0.023923	96,075	2,298	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,235	1,076,262	0.009510	91,646	872	67.00
68.00	06800	SPEECH PATHOLOGY	14,079	322,023	0.043720	23,592	1,031	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	672	704,304	0.000954	120,784	115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,018	10,404	0.386198	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,897	3,254,870	0.020246	576,891	11,680	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	257,012	20,607,105	0.012472	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	103,336	419,752	0.246183	0	0	92.00
200.00		Total (lines 50-199)	1,089,813	56,978,735		1,516,143	31,290	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part IV Date/Time Prepared: 11/13/2017 1:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part IV Date/Time Prepared: 11/13/2017 1:27 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	3,493,474	0.000000	0.000000	53,328	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	982,719	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,581,180	0.000000	0.000000	142,527	54.00
60.00	06000	LABORATORY	0	8,610,489	0.000000	0.000000	146,876	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,177,709	0.000000	0.000000	264,424	65.00
66.00	06600	PHYSICAL THERAPY	0	2,738,444	0.000000	0.000000	96,075	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,076,262	0.000000	0.000000	91,646	67.00
68.00	06800	SPEECH PATHOLOGY	0	322,023	0.000000	0.000000	23,592	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	704,304	0.000000	0.000000	120,784	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,404	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,254,870	0.000000	0.000000	576,891	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	20,607,105	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	419,752	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	56,978,735			1,516,143	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part IV Date/Time Prepared: 11/13/2017 1:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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
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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part V Date/Time Prepared: 11/13/2017 1:27 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	0.563287	0	958,993	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.104379	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173046	0	3,361,561	0	0	54.00
60.00	06000	LABORATORY	0.191446	0	2,371,403	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.478994	0	520,452	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.286326	0	868,554	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.235572	0	289,340	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.657872	0	14,855	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.033953	0	173,813	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3.202807	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.367344	0	736,622	2,713	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.245119	0	4,300,822	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.004191	0	134,966	0	0	92.00
200.00		Subtotal (see instructions)		0	13,731,381	2,713	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	13,731,381	2,713	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part V Date/Time Prepared: 11/13/2017 1:27 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	540,188	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	581,705	0		54.00
60.00	06000	LABORATORY	453,996	0		60.00
65.00	06500	RESPIRATORY THERAPY	249,293	0		65.00
66.00	06600	PHYSICAL THERAPY	248,690	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	68,160	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,773	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,901	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	270,594	997		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,054,213	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	270,498	0		92.00
200.00		Subtotal (see instructions)	3,753,011	997		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,753,011	997		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1316 | Component CCN: 15-Z316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part V Date/Time Prepared: 11/13/2017 1:27 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	0.563287	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.104379	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173046	0	0	0	0	54.00
60.00	06000	LABORATORY	0.191446	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.478994	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.286326	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.235572	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.657872	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.033953	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3.202807	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.367344	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.245119	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.004191	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: 15-1316 | Component CCN: 15-Z316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part V Date/Time Prepared: 11/13/2017 1:27 pm

Title XVIII | Swing Beds - SNF | Cost

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part III Date/Time Prepared: 11/13/2017 1:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,262	0.00	10	0		30.00
43.00	04300	NURSERY	186	0.00	74	0		43.00
200.00		Total (lines 30-199)	1,448		84	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part IV Date/Time Prepared: 11/13/2017 1:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part IV Date/Time Prepared: 11/13/2017 1:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,493,474	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	982,719	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,581,180	0.000000	0.000000	15,808	54.00
60.00	06000	LABORATORY	0	8,610,489	0.000000	0.000000	58,855	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,177,709	0.000000	0.000000	567	65.00
66.00	06600	PHYSICAL THERAPY	0	2,738,444	0.000000	0.000000	2,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,076,262	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	322,023	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	704,304	0.000000	0.000000	3,631	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,404	0.000000	0.000000	22	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,254,870	0.000000	0.000000	32,973	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	20,607,105	0.000000	0.000000	19,643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	419,752	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	56,978,735			134,016	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D Part IV | Date/Time Prepared: 11/13/2017 1:27 pm

Title XIX | Hospital | Cost

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet D-1 Date/Time Prepared: 11/13/2017 1:27 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)	1,505	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,262	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)	938	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	117	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)	116	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	5	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)	5	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	526	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)	100	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)	99	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)	3,883,126	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)	687	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)	687	25.00
26.00	Total swing-bed cost (see instructions)	606,356	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,276,770	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)	3,276,770	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)	2,596.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,365,754	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,365,754	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D-1 | Date/Time Prepared: 11/13/2017 1:27 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	490,117	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,855,871	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)	259,649	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	257,053	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	516,702	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)	324	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,596.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	841,263	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D-1 | Date/Time Prepared: 11/13/2017 1:27 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	476,979	3,883,126	0.122834	841,263	103,336	90.00
91.00	Nursing School cost	0	3,883,126	0.000000	841,263	0	91.00
92.00	Allied health cost	0	3,883,126	0.000000	841,263	0	92.00
93.00	All other Medical Education	0	3,883,126	0.000000	841,263	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet D-1 Date/Time Prepared: 11/13/2017 1:27 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)	1,505	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,262	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)	938	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	117	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)	116	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	5	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)	5	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	10	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)	186	15.00
16.00	Nursery days (title V or XIX only)	74	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)	3,883,126	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)	687	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)	687	25.00
26.00	Total swing-bed cost (see instructions)	606,356	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,276,770	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)	3,276,770	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)	2,596.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	25,965	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)	25,965	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D-1 | Date/Time Prepared: 11/13/2017 1:27 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)	327,486	186	1,760.68	74	130,290	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)	32,117	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	188,372	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)	324	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,596.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	841,263	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D-1 | Date/Time Prepared: 11/13/2017 1:27 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	476,979	3,883,126	0.122834	841,263	103,336	90.00
91.00	Nursing School cost	0	3,883,126	0.000000	841,263	0	91.00
92.00	Allied health cost	0	3,883,126	0.000000	841,263	0	92.00
93.00	All other Medical Education	0	3,883,126	0.000000	841,263	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D-3 | Date/Time Prepared: 11/13/2017 1:27 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		703,840		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.563287	53,328	30,039	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.104379	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173046	142,527	24,664	54.00
60.00	06000	LABORATORY	0.191446	146,876	28,119	60.00
65.00	06500	RESPIRATORY THERAPY	0.478994	264,424	126,658	65.00
66.00	06600	PHYSICAL THERAPY	0.286326	96,075	27,509	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.235572	91,646	21,589	67.00
68.00	06800	SPEECH PATHOLOGY	0.657872	23,592	15,521	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.033953	120,784	4,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3.202807	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.367344	576,891	211,917	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.245119	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.004191	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,516,143	490,117	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)		1,516,143		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1316 | Component CCN: 15-Z316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D-3 | Date/Time Prepared: 11/13/2017 1:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.563287	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.104379	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173046	11,056	1,913	54.00
60.00	06000	LABORATORY	0.191446	29,466	5,641	60.00
65.00	06500	RESPIRATORY THERAPY	0.478994	67,465	32,315	65.00
66.00	06600	PHYSICAL THERAPY	0.286326	119,616	34,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.235572	136,147	32,072	67.00
68.00	06800	SPEECH PATHOLOGY	0.657872	26,038	17,130	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.033953	19,195	652	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3.202807	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.367344	223,646	82,155	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.245119	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.004191	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		632,629	206,127	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)		632,629		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet D-3 | Date/Time Prepared: 11/13/2017 1:27 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		311,835		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.563287	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.104379	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173046	15,808	2,736	54.00
60.00	06000	LABORATORY	0.191446	58,855	11,268	60.00
65.00	06500	RESPIRATORY THERAPY	0.478994	567	272	65.00
66.00	06600	PHYSICAL THERAPY	0.286326	2,517	721	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.235572	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.657872	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.033953	3,631	123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3.202807	22	70	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.367344	32,973	12,112	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.245119	19,643	4,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.004191	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		134,016	32,117	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)		134,016		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet E Part B Date/Time Prepared: 11/13/2017 1:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,754,008	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)	3,754,008	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)	3,791,548	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)	38,044	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,263,417	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)	1,490,087	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)	1,490,087	30.00
31.00	Primary payer payments	24	31.00
32.00	Subtotal (line 30 minus line 31)	1,490,063	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)	730,791	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	475,014	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	486,643	36.00
37.00	Subtotal (see instructions)	1,965,077	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)	1,965,077	40.00
40.01	Sequestration adjustment (see instructions)	39,302	40.01
41.00	Interim payments	1,314,467	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	611,308	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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/13/2017 1:27 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		926,257		1,314,467	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		926,257		1,314,467	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		768,569		611,308	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,694,826		1,925,775	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: 15-1316 | Component CCN: 15-Z316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/13/2017 1:27 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		360,060		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	01/11/2017	32,200		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)		32,200		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)		392,260		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		321,776		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		714,036		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet E-1 Part II Date/Time Prepared: 11/13/2017 1:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	328	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	526	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	101	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	938	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	58,989,982	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,789,013	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1316 Component CCN: 15-Z316	Period: From 07/01/2016 To 05/31/2017	Worksheet E-2 Date/Time Prepared: 11/13/2017 1:27 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)	521,869	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)	208,188	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	199	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)	730,057	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	730,057	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)	730,057	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,449	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)	728,608	0	15.00
16.00		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	728,608	0	19.00
19.01	Sequestration adjustment (see instructions)	14,572	0	19.01
20.00	Interim payments	392,260	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)	321,776	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: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet E-3 Part V Date/Time Prepared: 11/13/2017 1:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,855,871	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)	1,855,871	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,874,430	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)	1,874,430	19.00
20.00	Deductibles (exclude professional component)	166,180	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,708,250	22.00
23.00	Coinsurance	3,290	23.00
24.00	Subtotal (line 22 minus line 23)	1,704,960	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,621	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	24,454	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,083	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,729,414	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)	1,729,414	30.00
30.01	Sequestration adjustment (see instructions)	34,588	30.01
31.00	Interim payments	926,257	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)	768,569	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: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/13/2017 1:27 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	188,372		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)	188,372	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)	188,372	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	311,835		8.00
9.00	Ancillary service charges	134,016	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)	445,851	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)	445,851	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	257,479	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)	188,372	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)	188,372	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)	188,372	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)	188,372	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	188,372	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)	188,372	0	40.00
41.00	Interim payments	188,372	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: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet G | Date/Time Prepared: 11/13/2017 1:27 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	99	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,790,207	0	0	0	4.00
5.00	Other receivable	3,420,966	9,605	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,506,874	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	239	0	0	0	8.00
9.00	Other current assets	1,537,892	0	0	0	9.00
10.00	Due from other funds	-39,227	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,203,302	9,605	0	0	11.00
	FIXED ASSETS					
12.00	Land	160,146	0	0	0	12.00
13.00	Land improvements	470	0	0	0	13.00
14.00	Accumulated depreciation	-470	0	0	0	14.00
15.00	Buildings	3,432,539	0	0	0	15.00
16.00	Accumulated depreciation	-661,495	0	0	0	16.00
17.00	Leasehold improvements	957,736	0	0	0	17.00
18.00	Accumulated depreciation	-510,747	0	0	0	18.00
19.00	Fixed equipment	684,582	0	0	0	19.00
20.00	Accumulated depreciation	-541,527	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	-5,001,482	0	0	0	23.00
24.00	Accumulated depreciation	1,656,821	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)	176,573	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	14,097	39,227	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,097	39,227	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	6,393,972	48,832	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,848,768	0	0	0	37.00
38.00	Salaries, wages, and fees payable	215,374	0	0	0	38.00
39.00	Payroll taxes payable	11,493	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,941,446	9,605	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,017,081	9,605	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	466,939	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	466,939	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,484,020	9,605	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,090,048				52.00
53.00	Specific purpose fund		39,227			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)	-1,090,048	39,227	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6,393,972	48,832	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet G-1 | Date/Time Prepared: 11/13/2017 1:27 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		46,245,099		39,234		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		433,285				2.00
3.00	Total (sum of line 1 and line 2)		46,678,384		39,234		3.00
4.00	TEMP RESTRICTED GRANT REVENUE	0		124,493		0	4.00
5.00	ROUNDING	3		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		3		124,493		10.00
11.00	Subtotal (line 3 plus line 10)		46,678,387		163,727		11.00
12.00	CONTRIBUTIONS/DONATIONS/GRANTS	263,577		0		0	12.00
13.00	TRANSFER TO AFFILIATES	47,504,858		0		0	13.00
14.00	TEMP RESTRICTED REL OPERATIONS	0		124,500		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		47,768,435		124,500		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,090,048		39,227		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	TEMP RESTRICTED GRANT REVENUE		0			4.00
5.00	ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	CONTRIBUTIONS/DONATIONS/GRANTS		0			12.00
13.00	TRANSFER TO AFFILIATES		0			13.00
14.00	TEMP RESTRICTED REL OPERATIONS		0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1316 | Period: From 07/01/2016 To 05/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/13/2017 1:27 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,232,615		3,232,615	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)	3,232,615		3,232,615	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)	3,232,615		3,232,615	17.00
18.00	Ancillary services	3,494,992	31,253,532	34,748,524	18.00
19.00	Outpatient services	212,842	20,796,001	21,008,843	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	PHYSICIAN REVENUE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,940,449	52,049,533	58,989,982	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,425,404		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,425,404		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1316	Period: From 07/01/2016 To 05/31/2017	Worksheet G-3 Date/Time Prepared: 11/13/2017 1:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	58,989,982	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,899,604	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,090,378	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,425,404	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-335,026	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	73,988	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	74	17.00
18.00	Revenue from sale of medical records and abstracts	9,787	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	60,205	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	605,225	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	6,538	24.01
24.02	BARBER AND BEAUTY	12,494	24.02
25.00	Total other income (sum of lines 6-24)	768,311	25.00
26.00	Total (line 5 plus line 25)	433,285	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	433,285	29.00