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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151335	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/21/2016 10:38 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2016 Time: 10:38 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST VINCENT DUNN (151335) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	485,800	168,211	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	56,581	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	542,381	168,211	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 3:27 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1616 TWENTY-THIRD STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421	County: LAWRENCE	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 DUNN	151335	99915	1	07/01/1966	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 DUNN	15Z335	99915		03/03/2012	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 3:27 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.				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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 3:27 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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 3:27 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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	63,047	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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 3:27 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	15H046	140.00

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		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: 151335	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 3:27 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	12/31/2015	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 3:27 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)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/04/2016	Y	10/04/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 3:27 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.HILL@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151335	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 3:27 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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2016 3:27 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	9,150	52,944.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	52,944.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	52,944.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/17/2016 3:27 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)	1,141	45	2,206			1.00
2.00	HMO and other (see instructions)	183	450				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	260	0	281			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	72			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,401	45	2,559			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		34	471			13.00
14.00	Total (see instructions)	1,401	79	3,030	0.00	134.61	14.00
15.00	CAH visits	9,432	727	29,508			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	134.61	27.00
28.00	Observation Bed Days		0	388			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	1	71			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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2016 3:27 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	284	24	686	1.00
2.00	HMO and other (see instructions)			50	166		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	284	24	686	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/17/2016 3:27 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)	0.377666	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,040,479	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	15,266,334	6.00
7.00	Medicaid cost (line 1 times line 6)	5,765,575	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)	1,725,096	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,725,096	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,271,861	458,760	1,730,621	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	480,339	173,258	653,597	21.00
22.00	Partial payment by patients approved for charity care	103,874	26,856	130,730	22.00
23.00	Cost of charity care (line 21 minus line 22)	376,465	146,402	522,867	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,072,506	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	312,332	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,760,174	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,042,424	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,565,291	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,290,387	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/17/2016 3:27 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		573,944	573,944	-4,183	569,761	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		400,812	400,812	0	400,812	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	70,058	2,626,801	2,696,859	0	2,696,859	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,670,063	1,869,115	3,539,178	4,183	3,543,361	5.00
7.00	00700	OPERATION OF PLANT	0	2,107,401	2,107,401	0	2,107,401	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,756	56,756	0	56,756	8.00
9.00	00900	HOUSEKEEPING	0	419,559	419,559	0	419,559	9.00
10.00	01000	DIETARY	0	621,201	621,201	-471,738	149,463	10.00
11.00	01100	CAFETERIA	0	0	0	471,738	471,738	11.00
13.00	01300	NURSING ADMINISTRATION	263,624	58,236	321,860	0	321,860	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,124	40,684	145,808	0	145,808	14.00
15.00	01500	PHARMACY	270,869	563,873	834,742	0	834,742	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	244,901	85,427	330,328	0	330,328	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,006,082	217,926	2,224,008	-726,830	1,497,178	30.00
43.00	04300	NURSERY	0	0	0	210,512	210,512	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	666,281	510,852	1,177,133	-92,093	1,085,040	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	493,258	493,258	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	701,289	344,912	1,046,201	0	1,046,201	54.00
60.00	06000	LABORATORY	0	1,472,501	1,472,501	0	1,472,501	60.00
65.00	06500	RESPIRATORY THERAPY	349,508	10,648	360,156	0	360,156	65.00
66.00	06600	PHYSICAL THERAPY	210,075	16,615	226,690	-1,525	225,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,526	891	17,417	0	17,417	67.00
68.00	06800	SPEECH PATHOLOGY	5,732	0	5,732	0	5,732	68.00
69.00	06900	ELECTROCARDIOLOGY	188,078	-37	188,041	0	188,041	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,121	20,121	133,865	153,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	390,111	390,111	0	390,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,254	0	1,254	0	1,254	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	53,062	9,331	62,393	0	62,393	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	100,703	100,703	0	100,703	76.00
76.97	07697	CARDIAC REHABILITATION	17,529	1,533	19,062	0	19,062	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	806,807	932,243	1,739,050	-17,187	1,721,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,646,862	13,452,159	21,099,021	0	21,099,021	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	34,076	0	34,076	0	34,076	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	1,031	1,031	0	1,031	194.03
194.04	07954	GRANTS	0	2,873	2,873	0	2,873	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	29,492	29,492	0	29,492	194.06
200.00		TOTAL (SUM OF LINES 118-199)	7,680,938	13,485,555	21,166,493	0	21,166,493	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/17/2016 3:27 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	-58,388	511,373		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	400,812		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	240,958	2,937,817		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	931,156	4,474,517		5.00
7.00	00700	OPERATION OF PLANT	-76,606	2,030,795		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,756		8.00
9.00	00900	HOUSEKEEPING	0	419,559		9.00
10.00	01000	DIETARY	0	149,463		10.00
11.00	01100	CAFETERIA	-89,668	382,070		11.00
13.00	01300	NURSING ADMINISTRATION	-670	321,190		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-723	145,085		14.00
15.00	01500	PHARMACY	-7,488	827,254		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,831	323,497		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,497,178		30.00
43.00	04300	NURSERY	0	210,512		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,085,040		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	493,258		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,046,201		54.00
60.00	06000	LABORATORY	0	1,472,501		60.00
65.00	06500	RESPIRATORY THERAPY	0	360,156		65.00
66.00	06600	PHYSICAL THERAPY	-22	225,143		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17,417		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,732		68.00
69.00	06900	ELECTROCARDIOLOGY	-41,968	146,073		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	153,986		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	390,111		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,254		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	62,393		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	100,703		76.00
76.97	07697	CARDIAC REHABILITATION	0	19,062		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	1,721,863		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	889,750	21,988,771		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	MARKETING	71,320	71,320		194.00
194.01	07951	FOUNDATION	0	34,076		194.01
194.02	07952	COMMUNITY OUTREACH	0	0		194.02
194.03	07953	WIC	0	1,031		194.03
194.04	07954	GRANTS	0	2,873		194.04
194.05	07955	VACANT SPACE	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	0	29,492		194.06
200.00		TOTAL (SUM OF LINES 118-199)	961,070	22,127,563		200.00

RECLASSIFICATIONS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/17/2016 3:27 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	471,738		1.00
	TOTALS		0	471,738		
	B - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,183		1.00
	TOTALS		0	4,183		
	C - NURSERY AND L&D					
1.00	NURSERY	43.00	190,622	22,951		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	446,654	53,777		2.00
	TOTALS		637,276	76,728		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	133,865		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		0	133,865		
500.00	Grand Total: Increases		637,276	686,514		500.00

RECLASSIFICATIONS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/17/2016 3:27 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	471,738	0		1.00
	TOTALS		0	471,738			
	B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,183	9		1.00
	TOTALS		0	4,183			
	C - NURSERY AND L&D						
1.00	ADULTS & PEDIATRICS	30.00	637,276	76,728	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		637,276	76,728			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	12,826	0		1.00
2.00	NURSERY	43.00	0	3,061	0		2.00
3.00	OPERATING ROOM	50.00	0	92,093	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,173	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	1,525	0		5.00
6.00	EMERGENCY	91.00	0	17,187	0		6.00
	TOTALS		0	133,865			
500.00	Grand Total: Decreases		637,276	686,514			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/17/2016 3:27 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	100,000	0	0	0	0	1.00
2.00	Land Improvements	60,000	23,405	0	23,405	0	2.00
3.00	Buildings and Fixtures	5,697,790	416,692	0	416,692	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,546,636	637,791	0	637,791	0	5.00
6.00	Movable Equipment	3,405,821	60,036	0	60,036	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,810,247	1,137,924	0	1,137,924	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	10,810,247	1,137,924	0	1,137,924	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	100,000	0	1.00
2.00	Land Improvements	83,405	0	2.00
3.00	Buildings and Fixtures	6,114,482	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,184,427	0	5.00
6.00	Movable Equipment	3,465,857	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,948,171	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	11,948,171	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/17/2016 3:27 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	316,914	0	235,150	21,100	780	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	400,077	0	0	735	0	2.00
3.00	Total (sum of lines 1-2)	716,991	0	235,150	21,835	780	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	573,944		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	400,812		2.00
3.00	Total (sum of lines 1-2)	0	974,756		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/17/2016 3:27 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	6,297,887	0	6,297,887	0.527101	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,650,284	0	5,650,284	0.472899	0	2.00
3.00	Total (sum of lines 1-2)	11,948,171	0	11,948,171	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: 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	254,343	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	400,077	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	654,420	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	235,150	21,100	780	0	511,373	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	735	0	0	400,812	2.00
3.00	Total (sum of lines 1-2)	235,150	21,835	780	0	912,185	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/17/2016 3:27 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	-41,588	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-753	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,892	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,581	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-69,368			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	1,676,994			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-89,668	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	-6,831	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	LOBBYING OFFSET	A	-950	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01			0		0.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/17/2016 3:27 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	HOSPITAL PROVIDER TAX	A	-531,573	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ENTERTAINMENT	A	-1,389	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	ENTERTAINMENT	A	-1,662	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CHARITABLE EXPENSE	A	-590	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ENTERTAINMENT	A	-22	PHYSICAL THERAPY	66.00	0	33.06
33.07	MARKETING	A	-595	NURSING ADMINISTRATION	13.00	0	33.07
33.08	LATE PENALTY FEES	A	-723	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	PROMOTIONAL ITEMS	A	-3,699	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	MISC. REVENUE - NURSING ADMIN	B	-75	NURSING ADMINISTRATION	13.00	0	33.10
33.11	MISC. REVENUE - PHARMACY	B	-7,488	PHARMACY	15.00	0	33.11
33.12	MISC. REVENUE - ADMINISTRATION	B	-17,513	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	LOSS ON SALE DISPOSAL PPE	A	-11,519	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	MARKETING COSTS	A	-4,077	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	ACCRUED INCENTIVES	A	321,534	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	ACCRUED INCENTIVES	A	-233,902	ADMINISTRATIVE & GENERAL	5.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		961,070				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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/17/2016 3:27 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	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,748,996	987,597	2.00
3.00	194.00	MARKETING	HOME OFFICE	71,320	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST VINCENT HLTH CHARGEBACK	252,456	252,456	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ST VINCENT HLTH CHARGEBACK	515,410	515,410	4.01
4.02	13.00	NURSING ADMINISTRATION	ST VINCENT HLTH CHARGEBACK	1,001	1,001	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	ST VINCENT HLTH CHARGEBACK	120,690	120,690	4.03
4.04	15.00	PHARMACY	ST VINCENT HLTH CHARGEBACK	14,706	14,706	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	ST VINCENT HLTH CHARGEBACK	56,308	56,308	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	ST VINCENT HLTH CHARGEBACK	15,727	15,727	4.06
4.07	75.01	SLEEP DISORDER	ST VINCENT HLTH CHARGEBACK	8,400	8,400	4.07
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	1,051,621	1,159,167	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	214,167	230,967	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	3,879	4,183	4.10
4.11	7.00	OPERATION OF PLANT	TRIMEDX	1,106,353	1,169,486	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	309,386	277,328	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
4.22	0.00			0	0	4.22
4.23	0.00			0	0	4.23
4.24	0.00			0	0	4.24
4.25	0.00			0	0	4.25
4.26	0.00			0	0	4.26
5.00	0		0	6,490,420	4,813,426	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151335	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-1 Date/Time Prepared: 11/17/2016 3:27 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	1,761,399	0		2.00
3.00	71,320	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	-107,546	0		4.08
4.09	-16,800	9		4.09
4.10	-304	9		4.10
4.11	-63,133	0		4.11
4.12	32,058	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
5.00	1,676,994			5.00

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

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

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

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

6.00	ADMINISTRATION		6.00
7.00	ADMINISTRATION		7.00
8.00	HOSPITAL		8.00
9.00	TRIMEDX		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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/17/2016 3:27 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	5.00	ADMINISTRATIVE & GENERAL	27,400	27,400	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	41,968	41,968	0	0	0	2.00
3.00	91.00	EMERGENCY	850,535	0	850,535	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			919,903	69,368	850,535		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	27,400		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	41,968		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	69,368		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 3:27 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	511,373	511,373				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	400,812		400,812			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,937,817	2,168	1,699	2,941,684		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,474,517	54,810	42,960	645,501	5,217,788	5.00
7.00	00700	OPERATION OF PLANT	2,030,795	66,785	52,346	0	2,149,926	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,756	7,047	5,524	0	69,327	8.00
9.00	00900	HOUSEKEEPING	419,559	7,154	5,607	0	432,320	9.00
10.00	01000	DIETARY	149,463	23,614	18,508	0	191,585	10.00
11.00	01100	CAFETERIA	382,070	0	0	0	382,070	11.00
13.00	01300	NURSING ADMINISTRATION	321,190	7,996	6,267	101,893	437,346	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	145,085	16,319	12,791	40,631	214,826	14.00
15.00	01500	PHARMACY	827,254	9,077	7,115	104,694	948,140	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	323,497	25,393	19,903	94,657	463,450	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,497,178	45,341	35,538	529,057	2,107,114	30.00
43.00	04300	NURSERY	210,512	2,593	2,032	73,677	288,814	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,085,040	53,889	42,238	257,524	1,438,691	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	493,258	31,337	24,562	172,636	721,793	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,046,201	38,367	30,072	271,055	1,385,695	54.00
60.00	06000	LABORATORY	1,472,501	13,574	10,639	0	1,496,714	60.00
65.00	06500	RESPIRATORY THERAPY	360,156	9,148	7,170	135,088	511,562	65.00
66.00	06600	PHYSICAL THERAPY	225,143	14,821	11,617	81,196	332,777	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,417	898	704	6,387	25,406	67.00
68.00	06800	SPEECH PATHOLOGY	5,732	755	591	2,215	9,293	68.00
69.00	06900	ELECTROCARDIOLOGY	146,073	9,336	7,318	72,694	235,421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,986	0	0	0	153,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	390,111	0	0	0	390,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,254	0	0	485	1,739	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	62,393	6,059	4,749	20,509	93,710	75.01
76.00	03950	SENIOR RENEWAL CENTER	100,703	3,680	2,884	0	107,267	76.00
76.97	07697	CARDIAC REHABILITATION	19,062	983	770	6,775	27,590	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,721,863	24,613	19,292	311,839	2,077,607	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)	21,988,771	475,757	372,896	2,928,513	21,912,068	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,760	1,379	0	3,139	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,223	26,040	0	59,263	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	71,320	0	0	0	71,320	194.00
194.01	07951	FOUNDATION	34,076	633	497	13,171	48,377	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	1,031	0	0	0	1,031	194.03
194.04	07954	GRANTS	2,873	0	0	0	2,873	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	29,492	0	0	0	29,492	194.06
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,127,563	511,373	400,812	2,941,684	22,127,563	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 3:27 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	5,217,788					5.00
7.00	00700	OPERATION OF PLANT	663,398	2,813,324				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,392	47,299	138,018			8.00
9.00	00900	HOUSEKEEPING	133,399	48,018	0	613,737		9.00
10.00	01000	DIETARY	59,117	158,490	0	35,788	444,980	10.00
11.00	01100	CAFETERIA	117,894	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	134,950	53,668	0	12,118	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,288	109,528	0	24,732	0	14.00
15.00	01500	PHARMACY	292,564	60,924	0	13,757	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	143,005	170,433	0	38,484	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	650,184	304,319	37,881	68,716	444,980	30.00
43.00	04300	NURSERY	89,118	17,404	9,078	3,930	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	443,931	361,688	12,719	81,671	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	222,721	210,325	21,290	47,492	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	427,578	257,511	15,899	58,147	0	54.00
60.00	06000	LABORATORY	461,835	91,103	0	20,571	0	60.00
65.00	06500	RESPIRATORY THERAPY	157,851	61,397	0	13,864	0	65.00
66.00	06600	PHYSICAL THERAPY	102,684	99,474	4,424	22,462	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,839	6,028	276	1,361	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,868	5,064	46	1,144	0	68.00
69.00	06900	ELECTROCARDIOLOGY	72,643	62,663	5,253	14,150	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,515	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	120,375	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	537	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	28,916	40,667	0	9,183	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	33,099	24,699	0	5,577	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,513	6,595	0	1,489	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	641,079	165,198	31,152	37,302	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,151,293	2,362,495	138,018	511,938	444,980	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	969	11,811	0	2,667	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	351,486	0	79,367	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	22,007	0	0	0	0	194.00
194.01	07951	FOUNDATION	14,927	4,252	0	960	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	33,316	0	7,523	0	194.02
194.03	07953	WIC	318	31,653	0	7,147	0	194.03
194.04	07954	GRANTS	887	18,311	0	4,135	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	9,100	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,217,788	2,813,324	138,018	613,737	444,980	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 3:27 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	499,964					11.00
13.00	01300	NURSING ADMINISTRATION	19,017	657,099				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,687	0	429,061			14.00
15.00	01500	PHARMACY	15,710	0	0	1,331,095		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,990	0	0	0	851,362	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	120,701	271,401	14,666	0	37,373	30.00
43.00	04300	NURSERY	14,209	31,949	3,501	0	7,965	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,364	124,487	105,302	0	197,275	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,296	74,866	8,202	0	18,663	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,639	0	0	0	216,310	54.00
60.00	06000	LABORATORY	0	0	0	0	165,085	60.00
65.00	06500	RESPIRATORY THERAPY	23,331	0	0	0	13,458	65.00
66.00	06600	PHYSICAL THERAPY	16,931	0	1,743	0	28,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	863	0	0	0	1,753	67.00
68.00	06800	SPEECH PATHOLOGY	155	0	0	0	179	68.00
69.00	06900	ELECTROCARDIOLOGY	12,459	0	0	0	30,130	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	78,110	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	197,885	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	234	0	0	1,331,095	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	4,295	0	0	0	4,711	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	2,511	76.00
76.97	07697	CARDIAC REHABILITATION	1,416	0	0	0	3,176	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	68,666	154,396	19,652	0	123,799	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	495,963	657,099	429,061	1,331,095	851,362	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	4,001	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
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)	499,964	657,099	429,061	1,331,095	851,362	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 3:27 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,057,335	0	4,057,335		30.00
43.00	04300	NURSERY	465,968	0	465,968		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,821,128	0	2,821,128		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,358,648	0	1,358,648		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,420,779	0	2,420,779		54.00
60.00	06000	LABORATORY	2,235,308	0	2,235,308		60.00
65.00	06500	RESPIRATORY THERAPY	781,463	0	781,463		65.00
66.00	06600	PHYSICAL THERAPY	609,469	0	609,469		66.00
67.00	06700	OCCUPATIONAL THERAPY	43,526	0	43,526		67.00
68.00	06800	SPEECH PATHOLOGY	18,749	0	18,749		68.00
69.00	06900	ELECTROCARDIOLOGY	432,719	0	432,719		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,611	0	279,611		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	708,371	0	708,371		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,333,605	0	1,333,605		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	181,482	0	181,482		75.01
76.00	03950	SENIOR RENEWAL CENTER	173,153	0	173,153		76.00
76.97	07697	CARDIAC REHABILITATION	48,779	0	48,779		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,318,851	0	3,318,851		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)	21,288,944	0	21,288,944		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,586	0	18,586		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	508,403	0	508,403		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MARKETING	93,327	0	93,327		194.00
194.01	07951	FOUNDATION	72,517	0	72,517		194.01
194.02	07952	COMMUNITY OUTREACH	40,839	0	40,839		194.02
194.03	07953	WIC	40,149	0	40,149		194.03
194.04	07954	GRANTS	26,206	0	26,206		194.04
194.05	07955	VACANT SPACE	0	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	38,592	0	38,592		194.06
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	22,127,563	0	22,127,563		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 3:27 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	317	2,168	1,699	4,184	4,184	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	387,892	54,810	42,960	485,662	915	5.00
7.00	00700	OPERATION OF PLANT	7,906	66,785	52,346	127,037	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,047	5,524	12,571	0	8.00
9.00	00900	HOUSEKEEPING	0	7,154	5,607	12,761	0	9.00
10.00	01000	DIETARY	0	23,614	18,508	42,122	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	589	7,996	6,267	14,852	145	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,319	12,791	29,110	58	14.00
15.00	01500	PHARMACY	48,472	9,077	7,115	64,664	149	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,046	25,393	19,903	47,342	135	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,627	45,341	35,538	122,506	753	30.00
43.00	04300	NURSERY	0	2,593	2,032	4,625	105	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	120,302	53,889	42,238	216,429	366	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	31,337	24,562	55,899	246	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	272,839	38,367	30,072	341,278	386	54.00
60.00	06000	LABORATORY	0	13,574	10,639	24,213	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,148	7,170	16,318	192	65.00
66.00	06600	PHYSICAL THERAPY	297	14,821	11,617	26,735	116	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	898	704	1,602	9	67.00
68.00	06800	SPEECH PATHOLOGY	0	755	591	1,346	3	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,336	7,318	16,654	103	69.00
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	1	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	29	6,059	4,749	10,837	29	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	3,680	2,884	6,564	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	983	770	1,753	10	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	24,613	19,292	43,905	444	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)	882,316	475,757	372,896	1,730,969	4,165	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,760	1,379	3,139	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,223	26,040	59,263	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	633	497	1,130	19	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	29,425	0	0	29,425	0	194.06
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)	911,741	511,373	400,812	1,823,926	4,184	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 3:27 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	486,577					5.00
7.00	00700	OPERATION OF PLANT	61,861	188,898				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,995	3,176	17,742			8.00
9.00	00900	HOUSEKEEPING	12,440	3,224	0	28,425		9.00
10.00	01000	DIETARY	5,513	10,642	0	1,657	59,934	10.00
11.00	01100	CAFETERIA	10,994	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	12,585	3,603	0	561	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,182	7,354	0	1,145	0	14.00
15.00	01500	PHARMACY	27,283	4,091	0	637	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,336	11,444	0	1,782	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,632	20,433	4,868	3,183	59,934	30.00
43.00	04300	NURSERY	8,311	1,169	1,167	182	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,398	24,287	1,635	3,785	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,770	14,122	2,737	2,200	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,873	17,290	2,044	2,693	0	54.00
60.00	06000	LABORATORY	43,068	6,117	0	953	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,720	4,122	0	642	0	65.00
66.00	06600	PHYSICAL THERAPY	9,576	6,679	569	1,040	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	731	405	36	63	0	67.00
68.00	06800	SPEECH PATHOLOGY	267	340	6	53	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,774	4,207	675	655	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,431	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,225	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	2,697	2,731	0	425	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	3,087	1,658	0	258	0	76.00
76.97	07697	CARDIAC REHABILITATION	794	443	0	69	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	59,783	11,092	4,005	1,728	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)	480,376	158,629	17,742	23,711	59,934	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	90	793	0	124	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,705	23,600	0	3,676	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	2,052	0	0	0	0	194.00
194.01	07951	FOUNDATION	1,392	285	0	44	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	2,237	0	348	0	194.02
194.03	07953	WIC	30	2,125	0	331	0	194.03
194.04	07954	GRANTS	83	1,229	0	191	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	849	0	0	0	0	194.06
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)	486,577	188,898	17,742	28,425	59,934	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 3:27 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	10,994					11.00
13.00	01300	NURSING ADMINISTRATION	418	32,164				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	301	0	44,150			14.00
15.00	01500	PHARMACY	345	0	0	97,169		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	791	0	0	0	74,830	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,658	13,285	1,509	0	3,284	30.00
43.00	04300	NURSERY	312	1,564	360	0	700	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,217	6,093	10,836	0	17,335	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	732	3,665	844	0	1,640	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,311	0	0	0	19,026	54.00
60.00	06000	LABORATORY	0	0	0	0	14,506	60.00
65.00	06500	RESPIRATORY THERAPY	513	0	0	0	1,183	65.00
66.00	06600	PHYSICAL THERAPY	372	0	179	0	2,546	66.00
67.00	06700	OCCUPATIONAL THERAPY	19	0	0	0	154	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	0	0	16	68.00
69.00	06900	ELECTROCARDIOLOGY	274	0	0	0	2,648	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	8,037	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	20,363	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5	0	0	97,169	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	94	0	0	0	414	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	221	76.00
76.97	07697	CARDIAC REHABILITATION	31	0	0	0	279	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,510	7,557	2,022	0	10,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,906	32,164	44,150	97,169	74,830	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	88	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
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)	10,994	32,164	44,150	97,169	74,830	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/17/2016 3:27 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	293,045	0	293,045		30.00
43.00	04300	NURSERY	18,495	0	18,495		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	323,381	0	323,381		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	102,855	0	102,855		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,901	0	423,901		54.00
60.00	06000	LABORATORY	88,857	0	88,857		60.00
65.00	06500	RESPIRATORY THERAPY	37,690	0	37,690		65.00
66.00	06600	PHYSICAL THERAPY	47,812	0	47,812		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,019	0	3,019		67.00
68.00	06800	SPEECH PATHOLOGY	2,034	0	2,034		68.00
69.00	06900	ELECTROCARDIOLOGY	31,990	0	31,990		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,468	0	12,468		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,588	0	31,588		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,225	0	97,225		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	17,227	0	17,227		75.01
76.00	03950	SENIOR RENEWAL CENTER	11,788	0	11,788		76.00
76.97	07697	CARDIAC REHABILITATION	3,379	0	3,379		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	142,924	0	142,924		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,689,678	0	1,689,678		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,146	0	4,146		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88,244	0	88,244		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MARKETING	2,052	0	2,052		194.00
194.01	07951	FOUNDATION	2,958	0	2,958		194.01
194.02	07952	COMMUNITY OUTREACH	2,585	0	2,585		194.02
194.03	07953	WIC	2,486	0	2,486		194.03
194.04	07954	GRANTS	1,503	0	1,503		194.04
194.05	07955	VACANT SPACE	0	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	30,274	0	30,274		194.06
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,823,926	0	1,823,926		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/17/2016 3:27 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	181,626					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		181,626				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	770	770	7,610,880			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,467	19,467	1,670,063	-5,217,788	16,909,775	5.00
7.00	00700	OPERATION OF PLANT	23,720	23,720	0	0	2,149,926	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,503	2,503	0	0	69,327	8.00
9.00	00900	HOUSEKEEPING	2,541	2,541	0	0	432,320	9.00
10.00	01000	DIETARY	8,387	8,387	0	0	191,585	10.00
11.00	01100	CAFETERIA	0	0	0	0	382,070	11.00
13.00	01300	NURSING ADMINISTRATION	2,840	2,840	263,624	0	437,346	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,796	5,796	105,124	0	214,826	14.00
15.00	01500	PHARMACY	3,224	3,224	270,869	0	948,140	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,019	9,019	244,901	0	463,450	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,104	16,104	1,368,806	0	2,107,114	30.00
43.00	04300	NURSERY	921	921	190,622	0	288,814	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,140	19,140	666,281	0	1,438,691	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,130	11,130	446,654	0	721,793	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,627	13,627	701,289	0	1,385,695	54.00
60.00	06000	LABORATORY	4,821	4,821	0	0	1,496,714	60.00
65.00	06500	RESPIRATORY THERAPY	3,249	3,249	349,508	0	511,562	65.00
66.00	06600	PHYSICAL THERAPY	5,264	5,264	210,075	0	332,777	66.00
67.00	06700	OCCUPATIONAL THERAPY	319	319	16,526	0	25,406	67.00
68.00	06800	SPEECH PATHOLOGY	268	268	5,732	0	9,293	68.00
69.00	06900	ELECTROCARDIOLOGY	3,316	3,316	188,078	0	235,421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	153,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	390,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,254	0	1,739	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	2,152	2,152	53,062	0	93,710	75.01
76.00	03950	SENIOR RENEWAL CENTER	1,307	1,307	0	0	107,267	76.00
76.97	07697	CARDIAC REHABILITATION	349	349	17,529	0	27,590	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,742	8,742	806,807	0	2,077,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	168,976	168,976	7,576,804	-5,217,788	16,694,280	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	625	0	0	3,139	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,800	11,800	0	0	59,263	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	71,320	194.00
194.01	07951	FOUNDATION	225	225	34,076	0	48,377	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	1,031	194.03
194.04	07954	GRANTS	0	0	0	0	2,873	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	29,492	194.06
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)	511,373	400,812	2,941,684		5,217,788	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.815528	2.206799	0.386510		0.308566	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,184		486,577	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000550		0.028775	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/17/2016 3:27 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (PAID HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	148,876					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,503	2,995				8.00
9.00	00900	HOUSEKEEPING	2,541	0	143,832			9.00
10.00	01000	DIETARY	8,387	0	8,387	2,206		10.00
11.00	01100	CAFETERIA	0	0	0	0	215,449	11.00
13.00	01300	NURSING ADMINISTRATION	2,840	0	2,840	0	8,195	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,796	0	5,796	0	5,898	14.00
15.00	01500	PHARMACY	3,224	0	3,224	0	6,770	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,019	0	9,019	0	15,509	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,104	822	16,104	2,206	52,014	30.00
43.00	04300	NURSERY	921	197	921	0	6,123	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,140	276	19,140	0	23,858	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,130	462	11,130	0	14,348	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,627	345	13,627	0	25,700	54.00
60.00	06000	LABORATORY	4,821	0	4,821	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,249	0	3,249	0	10,054	65.00
66.00	06600	PHYSICAL THERAPY	5,264	96	5,264	0	7,296	66.00
67.00	06700	OCCUPATIONAL THERAPY	319	6	319	0	372	67.00
68.00	06800	SPEECH PATHOLOGY	268	1	268	0	67	68.00
69.00	06900	ELECTROCARDIOLOGY	3,316	114	3,316	0	5,369	69.00
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	101	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	2,152	0	2,152	0	1,851	75.01
76.00	03950	SENIOR RENEWAL CENTER	1,307	0	1,307	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	349	0	349	0	610	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,742	676	8,742	0	29,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	125,019	2,995	119,975	2,206	213,725	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	0	625	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,600	0	18,600	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	225	0	225	0	1,724	194.01
194.02	07952	COMMUNITY OUTREACH	1,763	0	1,763	0	0	194.02
194.03	07953	WIC	1,675	0	1,675	0	0	194.03
194.04	07954	GRANTS	969	0	969	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,813,324	138,018	613,737	444,980	499,964	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.897096	46.082805	4.267041	201.713509	2.320568	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	188,898	17,742	28,425	59,934	10,994	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.268828	5.923873	0.197626	27.168631	0.051028	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/17/2016 3:27 pm

		Cost Center Description	NURSING ADMINISTRATION (PAID HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	125,933					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	845,851				14.00
15.00	01500	PHARMACY	0	0	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	50,821,795		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,014	28,912	0	2,230,966		30.00
43.00	04300	NURSERY	6,123	6,901	0	475,470		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,858	207,593	0	11,776,185		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,348	16,169	0	1,114,096		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,912,648		54.00
60.00	06000	LABORATORY	0	0	0	9,854,668		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	803,385		65.00
66.00	06600	PHYSICAL THERAPY	0	3,437	0	1,729,598		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	104,663		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,689		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,798,606		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	153,986	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	390,111	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,000	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0	0	281,242		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	149,892		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	189,586		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	29,590	38,742	0	7,390,101		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	125,933	845,851	10,000	50,821,795		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0		194.02
194.03	07953	WIC	0	0	0	0		194.03
194.04	07954	GRANTS	0	0	0	0		194.04
194.05	07955	VACANT SPACE	0	0	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0		194.06
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)	657,099	429,061	1,331,095	851,362		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.217846	0.507254	133.109500	0.016752		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,164	44,150	97,169	74,830		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.255406	0.052196	9.716900	0.001472		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 3:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,057,335		4,057,335	0	0	30.00
43.00	04300	NURSERY	465,968		465,968	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,821,128		2,821,128	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,358,648		1,358,648	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,420,779		2,420,779	0	0	54.00
60.00	06000	LABORATORY	2,235,308		2,235,308	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	781,463	0	781,463	0	0	65.00
66.00	06600	PHYSICAL THERAPY	609,469	0	609,469	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,526	0	43,526	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,749	0	18,749	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	432,719		432,719	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,611		279,611	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	708,371		708,371	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,333,605		1,333,605	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	181,482		181,482	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	173,153		173,153	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	48,779		48,779	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,318,851		3,318,851	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	546,261		546,261		0	92.00
200.00		Subtotal (see instructions)	21,835,205	0	21,835,205	0	0	200.00
201.00		Less Observation Beds	546,261		546,261		0	201.00
202.00		Total (see instructions)	21,288,944	0	21,288,944	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 3:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,982,834		1,982,834			30.00
43.00	04300	NURSERY	475,470		475,470			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,742,403	9,033,782	11,776,185	0.239562	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	899,315	214,781	1,114,096	1.219507	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	537,283	12,375,365	12,912,648	0.187473	0.000000	54.00
60.00	06000	LABORATORY	871,133	8,983,535	9,854,668	0.226827	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	418,269	385,116	803,385	0.972713	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	320,676	1,408,922	1,729,598	0.352376	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,041	76,622	104,663	0.415868	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	513	10,176	10,689	1.754046	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	205,098	1,593,508	1,798,606	0.240586	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	702,992	1,073,154	1,776,146	0.157426	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	600,093	460,610	1,060,703	0.667832	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,300,215	1,410,891	2,711,106	0.491904	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	281,242	281,242	0.645288	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	149,892	149,892	1.155185	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	189,586	189,586	0.257292	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	151,491	7,238,610	7,390,101	0.449094	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,534	239,598	248,132	2.201494	0.000000	92.00
200.00		Subtotal (see instructions)	11,244,360	45,125,390	56,369,750			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,244,360	45,125,390	56,369,750			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 3:27 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
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
75.01	07501	SLEEP DISORDER	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 3:27 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	4,057,335		4,057,335	0	4,057,335	30.00
43.00	04300	NURSERY	465,968		465,968	0	465,968	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,821,128		2,821,128	0	2,821,128	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,358,648		1,358,648	0	1,358,648	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,420,779		2,420,779	0	2,420,779	54.00
60.00	06000	LABORATORY	2,235,308		2,235,308	0	2,235,308	60.00
65.00	06500	RESPIRATORY THERAPY	781,463	0	781,463	0	781,463	65.00
66.00	06600	PHYSICAL THERAPY	609,469	0	609,469	0	609,469	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,526	0	43,526	0	43,526	67.00
68.00	06800	SPEECH PATHOLOGY	18,749	0	18,749	0	18,749	68.00
69.00	06900	ELECTROCARDIOLOGY	432,719		432,719	0	432,719	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,611		279,611	0	279,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	708,371		708,371	0	708,371	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,333,605		1,333,605	0	1,333,605	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	181,482		181,482	0	181,482	75.01
76.00	03950	SENIOR RENEWAL CENTER	173,153		173,153	0	173,153	76.00
76.97	07697	CARDIAC REHABILITATION	48,779		48,779	0	48,779	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,318,851		3,318,851	0	3,318,851	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	546,261		546,261		546,261	92.00
200.00		Subtotal (see instructions)	21,835,205	0	21,835,205	0	21,835,205	200.00
201.00		Less Observation Beds	546,261		546,261		546,261	201.00
202.00		Total (see instructions)	21,288,944	0	21,288,944	0	21,288,944	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 3:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,982,834		1,982,834			30.00
43.00	04300	NURSERY	475,470		475,470			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,742,403	9,033,782	11,776,185	0.239562	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	899,315	214,781	1,114,096	1.219507	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	537,283	12,375,365	12,912,648	0.187473	0.000000	54.00
60.00	06000	LABORATORY	871,133	8,983,535	9,854,668	0.226827	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	418,269	385,116	803,385	0.972713	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	320,676	1,408,922	1,729,598	0.352376	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,041	76,622	104,663	0.415868	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	513	10,176	10,689	1.754046	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	205,098	1,593,508	1,798,606	0.240586	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	702,992	1,073,154	1,776,146	0.157426	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	600,093	460,610	1,060,703	0.667832	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,300,215	1,410,891	2,711,106	0.491904	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	281,242	281,242	0.645288	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	149,892	149,892	1.155185	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	189,586	189,586	0.257292	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	151,491	7,238,610	7,390,101	0.449094	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,534	239,598	248,132	2.201494	0.000000	92.00
200.00		Subtotal (see instructions)	11,244,360	45,125,390	56,369,750			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,244,360	45,125,390	56,369,750			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 3:27 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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SLEEP DISORDER	0.000000		75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II Date/Time Prepared: 11/17/2016 3:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,821,128	323,381	2,497,747	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,358,648	102,855	1,255,793	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,420,779	423,901	1,996,878	0	0	54.00
60.00	06000	LABORATORY	2,235,308	88,857	2,146,451	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	781,463	37,690	743,773	0	0	65.00
66.00	06600	PHYSICAL THERAPY	609,469	47,812	561,657	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,526	3,019	40,507	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,749	2,034	16,715	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	432,719	31,990	400,729	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,611	12,468	267,143	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	708,371	31,588	676,783	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,333,605	97,225	1,236,380	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	181,482	17,227	164,255	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	173,153	11,788	161,365	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	48,779	3,379	45,400	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,318,851	142,924	3,175,927	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	546,261	39,454	506,807	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	17,311,902	1,417,592	15,894,310	0	0	200.00
201.00		Less Observation Beds	546,261	39,454	506,807	0	0	201.00
202.00		Total (line 200 minus line 201)	16,765,641	1,378,138	15,387,503	0	0	202.00

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

Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II Date/Time Prepared: 11/17/2016 3:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,821,128	11,776,185	0.239562		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,358,648	1,114,096	1.219507		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,420,779	12,912,648	0.187473		54.00
60.00	06000	LABORATORY	2,235,308	9,854,668	0.226827		60.00
65.00	06500	RESPIRATORY THERAPY	781,463	803,385	0.972713		65.00
66.00	06600	PHYSICAL THERAPY	609,469	1,729,598	0.352376		66.00
67.00	06700	OCCUPATIONAL THERAPY	43,526	104,663	0.415868		67.00
68.00	06800	SPEECH PATHOLOGY	18,749	10,689	1.754046		68.00
69.00	06900	ELECTROCARDIOLOGY	432,719	1,798,606	0.240586		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,611	1,776,146	0.157426		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	708,371	1,060,703	0.667832		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,333,605	2,711,106	0.491904		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
75.01	07501	SLEEP DISORDER	181,482	281,242	0.645288		75.01
76.00	03950	SENIOR RENEWAL CENTER	173,153	149,892	1.155185		76.00
76.97	07697	CARDIAC REHABILITATION	48,779	189,586	0.257292		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,318,851	7,390,101	0.449094		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	546,261	248,132	2.201494		92.00
200.00		Subtotal (sum of lines 50 thru 199)	17,311,902	53,911,446			200.00
201.00		Less Observation Beds	546,261	0			201.00
202.00		Total (line 200 minus line 201)	16,765,641	53,911,446			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/17/2016 3:27 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	323,381	11,776,185	0.027461	1,024,412	28,131	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	102,855	1,114,096	0.092321	3,771	348	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,901	12,912,648	0.032828	217,624	7,144	54.00
60.00	06000	LABORATORY	88,857	9,854,668	0.009017	392,408	3,538	60.00
65.00	06500	RESPIRATORY THERAPY	37,690	803,385	0.046914	136,289	6,394	65.00
66.00	06600	PHYSICAL THERAPY	47,812	1,729,598	0.027643	118,791	3,284	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,019	104,663	0.028845	2,759	80	67.00
68.00	06800	SPEECH PATHOLOGY	2,034	10,689	0.190289	513	98	68.00
69.00	06900	ELECTROCARDIOLOGY	31,990	1,798,606	0.017786	190,960	3,396	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,468	1,776,146	0.007020	388,789	2,729	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,588	1,060,703	0.029780	352,294	10,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,225	2,711,106	0.035862	660,762	23,696	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	17,227	281,242	0.061253	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	11,788	149,892	0.078643	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,379	189,586	0.017823	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	142,924	7,390,101	0.019340	25,833	500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,454	248,132	0.159004	0	0	92.00
200.00		Total (lines 50-199)	1,417,592	53,911,446		3,515,205	89,829	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 3:27 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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 3:27 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	11,776,185	0.000000	0.000000	1,024,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,114,096	0.000000	0.000000	3,771	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,912,648	0.000000	0.000000	217,624	54.00
60.00	06000	LABORATORY	0	9,854,668	0.000000	0.000000	392,408	60.00
65.00	06500	RESPIRATORY THERAPY	0	803,385	0.000000	0.000000	136,289	65.00
66.00	06600	PHYSICAL THERAPY	0	1,729,598	0.000000	0.000000	118,791	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	104,663	0.000000	0.000000	2,759	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,689	0.000000	0.000000	513	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,798,606	0.000000	0.000000	190,960	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,776,146	0.000000	0.000000	388,789	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,060,703	0.000000	0.000000	352,294	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,711,106	0.000000	0.000000	660,762	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	0	281,242	0.000000	0.000000	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	149,892	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	189,586	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	7,390,101	0.000000	0.000000	25,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	248,132	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	53,911,446			3,515,205	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/17/2016 3:27 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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/17/2016 3:27 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	0.239562	0	2,758,298	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.219507	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187473	0	3,778,012	0	0	54.00
60.00	06000	LABORATORY	0.226827	0	2,591,259	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.972713	0	42,543	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.352376	0	499,967	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415868	0	28,751	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.754046	0	1,831	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.240586	0	563,304	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157426	0	364,930	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.667832	0	84,523	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491904	0	365,150	12,717	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.645288	0	73,709	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	1.155185	0	148,553	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.257292	0	147,538	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.449094	0	1,905,399	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.201494	0	136,572	0	0	92.00
200.00		Subtotal (see instructions)		0	13,490,339	12,717	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	13,490,339	12,717	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/17/2016 3:27 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	660,783	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	708,275	0		54.00
60.00	06000	LABORATORY	587,768	0		60.00
65.00	06500	RESPIRATORY THERAPY	41,382	0		65.00
66.00	06600	PHYSICAL THERAPY	176,176	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,957	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,212	0		68.00
69.00	06900	ELECTROCARDIOLOGY	135,523	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,449	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,447	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	179,619	6,256		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	47,564	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	171,606	0		76.00
76.97	07697	CARDIAC REHABILITATION	37,960	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	855,703	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	300,662	0		92.00
200.00		Subtotal (see instructions)	4,032,086	6,256		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,032,086	6,256		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151335 | Component CCN: 15Z335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/17/2016 3:27 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	0.239562	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.219507	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187473	0	0	0	0	54.00
60.00	06000	LABORATORY	0.226827	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.972713	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.352376	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415868	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.754046	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.240586	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157426	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.667832	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491904	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.645288	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	1.155185	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.257292	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.449094	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.201494	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: 151335 | Component CCN: 15Z335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/17/2016 3:27 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
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/17/2016 3:27 pm

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	293,045	29,271	263,774	2,594	101.69	30.00
43.00	NURSERY	18,495		18,495	471	39.27	43.00
200.00	Total (lines 30-199)	311,540		282,269	3,065		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	45	4,576				30.00
43.00	NURSERY	34	1,335				43.00
200.00	Total (lines 30-199)	79	5,911				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/17/2016 3:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	323,381	11,776,185	0.027461	60,516	1,662	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	102,855	1,114,096	0.092321	64,397	5,945	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,901	12,912,648	0.032828	16,114	529	54.00
60.00	06000	LABORATORY	88,857	9,854,668	0.009017	29,161	263	60.00
65.00	06500	RESPIRATORY THERAPY	37,690	803,385	0.046914	15,551	730	65.00
66.00	06600	PHYSICAL THERAPY	47,812	1,729,598	0.027643	2,926	81	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,019	104,663	0.028845	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,034	10,689	0.190289	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,990	1,798,606	0.017786	2,908	52	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,468	1,776,146	0.007020	24,615	173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,588	1,060,703	0.029780	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,225	2,711,106	0.035862	20,909	750	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	17,227	281,242	0.061253	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	11,788	149,892	0.078643	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,379	189,586	0.017823	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	142,924	7,390,101	0.019340	11,510	223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,454	248,132	0.159004	336	53	92.00
200.00		Total (lines 50-199)	1,417,592	53,911,446		248,943	10,461	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/17/2016 3:27 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	2,594	0.00	45	0		30.00
43.00	04300	NURSERY	471	0.00	34	0		43.00
200.00		Total (lines 30-199)	3,065		79	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 3:27 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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 3:27 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	11,776,185	0.000000	0.000000	60,516	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,114,096	0.000000	0.000000	64,397	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,912,648	0.000000	0.000000	16,114	54.00
60.00	06000	LABORATORY	0	9,854,668	0.000000	0.000000	29,161	60.00
65.00	06500	RESPIRATORY THERAPY	0	803,385	0.000000	0.000000	15,551	65.00
66.00	06600	PHYSICAL THERAPY	0	1,729,598	0.000000	0.000000	2,926	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	104,663	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,689	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,798,606	0.000000	0.000000	2,908	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,776,146	0.000000	0.000000	24,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,060,703	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,711,106	0.000000	0.000000	20,909	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	0	281,242	0.000000	0.000000	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	149,892	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	189,586	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	7,390,101	0.000000	0.000000	11,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	248,132	0.000000	0.000000	336	92.00
200.00		Total (lines 50-199)	0	53,911,446			248,943	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 3:27 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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 3:27 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)		2,947	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,594	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)		2,206	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		141	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)		140	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		36	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)		36	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,141	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)		130	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)		130	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		134.09	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		134.09	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,057,335	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)		4,827	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)		4,827	25.00
26.00	Total swing-bed cost (see instructions)		405,271	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,652,064	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)		3,652,064	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,407.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,606,402	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)		1,606,402	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 3:27 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)	1,235,345	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,841,747	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)	183,026	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	183,026	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	366,052	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)	388	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,407.89	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	546,261	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 3:27 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	293,045	4,057,335	0.072226	546,261	39,454	90.00
91.00	Nursing School cost	0	4,057,335	0.000000	546,261	0	91.00
92.00	Allied health cost	0	4,057,335	0.000000	546,261	0	92.00
93.00	All other Medical Education	0	4,057,335	0.000000	546,261	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 3:27 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)	2,947	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,594	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)	2,206	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	141	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)	140	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	36	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)	36	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	45	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)	471	15.00
16.00	Nursery days (title V or XIX only)	34	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.09	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.09	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,057,335	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)	4,827	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)	4,827	25.00
26.00	Total swing-bed cost (see instructions)	405,271	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,652,064	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)	3,652,064	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,407.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	63,355	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)	63,355	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 3:27 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)	465,968	471	989.32	34	33,637	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)	139,593	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	236,585	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)	388	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,407.89	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	546,261	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 3:27 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	293,045	4,057,335	0.072226	546,261	39,454	90.00
91.00	Nursing School cost	0	4,057,335	0.000000	546,261	0	91.00
92.00	Allied health cost	0	4,057,335	0.000000	546,261	0	92.00
93.00	All other Medical Education	0	4,057,335	0.000000	546,261	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/17/2016 3:27 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		855,051		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.239562	1,024,412	245,410	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.219507	3,771	4,599	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187473	217,624	40,799	54.00
60.00	06000	LABORATORY	0.226827	392,408	89,009	60.00
65.00	06500	RESPIRATORY THERAPY	0.972713	136,289	132,570	65.00
66.00	06600	PHYSICAL THERAPY	0.352376	118,791	41,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415868	2,759	1,147	67.00
68.00	06800	SPEECH PATHOLOGY	1.754046	513	900	68.00
69.00	06900	ELECTROCARDIOLOGY	0.240586	190,960	45,942	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157426	388,789	61,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.667832	352,294	235,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491904	660,762	325,031	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	0.645288	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	1.155185	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.257292	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.449094	25,833	11,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.201494	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,515,205	1,235,345	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)		3,515,205		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151335 | Component CCN: 15Z335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/17/2016 3:27 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	0.239562	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.219507	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187473	3,757	704	54.00
60.00	06000	LABORATORY	0.226827	13,423	3,045	60.00
65.00	06500	RESPIRATORY THERAPY	0.972713	16,371	15,924	65.00
66.00	06600	PHYSICAL THERAPY	0.352376	100,177	35,300	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415868	18,151	7,548	67.00
68.00	06800	SPEECH PATHOLOGY	1.754046	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.240586	10,230	2,461	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157426	31,233	4,917	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.667832	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491904	83,452	41,050	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	0.645288	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	1.155185	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.257292	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.449094	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.201494	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		276,794	110,949	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)		276,794		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/17/2016 3:27 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		38,871		30.00
43.00	04300	NURSERY		27,483		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.239562	60,516	14,497	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.219507	64,397	78,533	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187473	16,114	3,021	54.00
60.00	06000	LABORATORY	0.226827	29,161	6,615	60.00
65.00	06500	RESPIRATORY THERAPY	0.972713	15,551	15,127	65.00
66.00	06600	PHYSICAL THERAPY	0.352376	2,926	1,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415868	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.754046	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.240586	2,908	700	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157426	24,615	3,875	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.667832	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491904	20,909	10,285	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	0.645288	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	1.155185	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.257292	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.449094	11,510	5,169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.201494	336	740	92.00
200.00		Total (sum of lines 50-94 and 96-98)		248,943	139,593	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)		248,943		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151335	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/17/2016 3:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,038,342	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,038,342	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,078,725	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)	32,485	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,193,340	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)	1,852,900	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)	1,852,900	30.00
31.00	Primary payer payments	835	31.00
32.00	Subtotal (line 30 minus line 31)	1,852,065	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)	449,011	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	291,857	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	379,983	36.00
37.00	Subtotal (see instructions)	2,143,922	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,143,922	40.00
40.01	Sequestration adjustment (see instructions)	42,878	40.01
41.00	Interim payments	1,932,833	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	168,211	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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2016 3:27 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		2,085,007		1,932,833	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)		2,085,007		1,932,833	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		485,800		168,211	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,570,807		2,101,044	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: 151335 | Component CCN: 15Z335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2016 3:27 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		411,541		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		411,541		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		56,581		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		468,122		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: 151335	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/17/2016 3:27 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	686	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,141	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	183	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,206	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	56,369,750	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,730,621	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: 151335 Component CCN: 15Z335	Period: From 07/01/2015 To 06/30/2016	Worksheet E-2 Date/Time Prepared: 11/17/2016 3:27 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)	369,713	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)	112,058	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	260	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)	481,771	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	481,771	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)	481,771	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,095	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)	477,676	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	477,676	0	19.00
19.01	Sequestration adjustment (see instructions)	9,554	0	19.01
20.00	Interim payments	411,541	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)	56,581	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: 151335	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/17/2016 3:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,841,747	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)	2,841,747	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,870,164	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)	2,870,164	19.00
20.00	Deductibles (exclude professional component)	267,367	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,602,797	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,602,797	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,500	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,475	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,230	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,623,272	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,623,272	30.00
30.01	Sequestration adjustment (see instructions)	52,465	30.01
31.00	Interim payments	2,085,007	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)	485,800	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: 151335	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/17/2016 3:27 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	236,585		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)	236,585	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)	236,585	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	66,354		8.00
9.00	Ancillary service charges	248,943	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)	315,297	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)	315,297	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	78,712	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)	236,585	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)	236,585	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)	236,585	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)	236,585	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	236,585	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)	236,585	0	40.00
41.00	Interim payments	236,585	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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/17/2016 3:27 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	152,231	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	6,064,428	0	0	0	4.00
5.00	Other receivable	1,235,395	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,600,462	0	0	0	6.00
7.00	Inventory	460,133	0	0	0	7.00
8.00	Prepaid expenses	5,310	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,317,035	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	100,000	0	0	0	12.00
13.00	Land improvements	83,405	0	0	0	13.00
14.00	Accumulated depreciation	-38,311	0	0	0	14.00
15.00	Buildings	6,114,482	0	0	0	15.00
16.00	Accumulated depreciation	-1,693,641	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,184,427	0	0	0	19.00
20.00	Accumulated depreciation	-1,123,070	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	3,465,857	0	0	0	23.00
24.00	Accumulated depreciation	-2,664,089	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)	6,429,060	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8,143,101	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,143,101	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,889,196	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	449,561	0	0	0	37.00
38.00	Salaries, wages, and fees payable	991,763	0	0	0	38.00
39.00	Payroll taxes payable	81,252	0	0	0	39.00
40.00	Notes and loans payable (short term)	98,324	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,785,188	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,406,088	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,401,875	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,401,875	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,807,963	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	8,081,233				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	8,081,233	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,889,196	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/17/2016 3:27 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		5,584,688		35,860		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,254,291				2.00
3.00	Total (sum of line 1 and line 2)		7,838,979		35,860		3.00
4.00	OTHER RESTRICTED ACTIVITY	0		0		0	4.00
5.00	GRANT REVENUE - FEDERAL	0		14,015		0	5.00
6.00	TRANSFER FROM AFFILIATES	0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00	ROUNDING	1		0		0	9.00
10.00	Total additions (sum of line 4-9)		1		14,015		10.00
11.00	Subtotal (line 3 plus line 10)		7,838,980		49,875		11.00
12.00	TRANSFER FROM AFFILIATES	-370,071		0		0	12.00
13.00	OTHER UNRESTRICTED ACTIVITY	0		0		0	13.00
14.00	DEFERRED PENSION COSTS ADMINISTERED	127,818		0		0	14.00
15.00	NET ASSETS RELEASED FROM RESTRICTION	0		49,875		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)		-242,253		49,875		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		8,081,233		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	OTHER RESTRICTED ACTIVITY		0			4.00
5.00	GRANT REVENUE - FEDERAL		0			5.00
6.00	TRANSFER FROM AFFILIATES		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00	ROUNDING		0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFER FROM AFFILIATES		0			12.00
13.00	OTHER UNRESTRICTED ACTIVITY		0			13.00
14.00	DEFERRED PENSION COSTS ADMINISTERED		0			14.00
15.00	NET ASSETS RELEASED FROM RESTRICTION		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: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/17/2016 3:27 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,709,447		3,709,447	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)	3,709,447		3,709,447	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)	3,709,447		3,709,447	17.00
18.00	Ancillary services	7,687,036	37,568,859	45,255,895	18.00
19.00	Outpatient services	160,025	7,468,653	7,628,678	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	COMMUNITY OUTREACH	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,556,508	45,037,512	56,594,020	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,166,493		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)		21,166,493		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151335 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-3 | Date/Time Prepared: 11/17/2016 3:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,594,020	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,326,259	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,267,761	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,166,493	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,101,268	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-1,092	6.00
7.00	Income from investments	-238,469	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	83,670	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	6,831	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	76,239	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	57,175	24.00
24.01	MISC DIETARY	5,998	24.01
24.03	BUILDING RENT	112,796	24.03
24.04	NET ASSETS RELEASED FROM RESTRICTION	49,875	24.04
25.00	Total other income (sum of lines 6-24)	153,023	25.00
26.00	Total (line 5 plus line 25)	2,254,291	26.00
27.00	NON-RECURRING EXPENSE	0	27.00
27.01	LOSS ON INTEREST RATE SWAP	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,254,291	29.00