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: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/22/2016 1:43 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report   Date: 11/22/2016   Time: 1:43 pm
2. [   ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT FRANKFORT HOSPITAL (151316) 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	141,959	-292,100	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	197,523	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	339,482	-292,100	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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 4:59 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 SOUTH JACKSON STREET	PO Box:			1.00
2.00	City: FRANKFORT	State: IN	Zip Code: 46041	County: CLINTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT FRANKFORT HOSPITAL	151316	99915	1	01/21/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT FRANKFORT HOSPITAL	15Z316	99915		01/21/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 4:59 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 4:59 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

		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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	66,124	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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 4:59 pm

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

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		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: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/17/2016 4:59 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: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 4:59 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/03/2016	Y	10/03/2016	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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 4:59 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: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/17/2016 4:59 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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2016 4:59 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	37,920.00	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	37,920.00	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	37,920.00	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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2016 4:59 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)	891	14	1,580			1.00
2.00	HMO and other (see instructions)	113	319				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	697	0	701			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	14			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,588	14	2,295			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		69	237			13.00
14.00	Total (see instructions)	1,588	83	2,532	0.00	106.36	14.00
15.00	CAH visits	9,648	748	32,178			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	106.36	27.00
28.00	Observation Bed Days		0	220			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	13	20			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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2016 4:59 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	260	15	523	1.00
2.00	HMO and other (see instructions)			32	118		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	260	15	523	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: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/17/2016 4:59 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)	0.278637	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,750,426	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	19,762,041	6.00
7.00	Medicaid cost (line 1 times line 6)	5,506,436	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)	1,756,010	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)	1,756,010	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	3,740,064	1,048,949	4,789,013	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,042,120	292,276	1,334,396	21.00
22.00	Partial payment by patients approved for charity care	205,250	38,655	243,905	22.00
23.00	Cost of charity care (line 21 minus line 22)	836,870	253,621	1,090,491	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)	3,153,459	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	648,966	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,504,493	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	697,844	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,788,335	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,544,345	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/17/2016 4:59 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		941,528	941,528	-267	941,261	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		560,411	560,411	0	560,411	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	207,268	1,656,238	1,863,506	0	1,863,506	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,780,570	3,207,470	4,988,040	267	4,988,307	5.00
7.00	00700	OPERATION OF PLANT	0	953,624	953,624	0	953,624	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	53,440	53,440	0	53,440	8.00
9.00	00900	HOUSEKEEPING	0	415,781	415,781	0	415,781	9.00
10.00	01000	DIETARY	0	522,536	522,536	-421,896	100,640	10.00
11.00	01100	CAFETERIA	0	0	0	421,896	421,896	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	660,126	7,193	667,319	0	667,319	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70,418	31,225	101,643	0	101,643	14.00
15.00	01500	PHARMACY	285,963	387,212	673,175	0	673,175	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,620	62,362	96,982	0	96,982	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,448,316	371,265	1,819,581	-728,110	1,091,471	30.00
43.00	04300	NURSERY	0	0	0	191,663	191,663	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	384,259	421,355	805,614	-11,829	793,785	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	529,950	529,950	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	615,230	545,378	1,160,608	0	1,160,608	54.00
60.00	06000	LABORATORY	0	1,241,103	1,241,103	0	1,241,103	60.00
65.00	06500	RESPIRATORY THERAPY	158,631	104,578	263,209	-1,390	261,819	65.00
66.00	06600	PHYSICAL THERAPY	0	551,550	551,550	-976	550,574	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	262,504	262,504	0	262,504	67.00
68.00	06800	SPEECH PATHOLOGY	87,204	-8,091	79,113	0	79,113	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,548	20,548	35,096	55,644	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,636	26,636	0	26,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	902,032	1,080,260	1,982,292	-14,404	1,967,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,634,637	13,416,106	20,050,743	0	20,050,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	778	778	0	778	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	10,308	10,308	0	10,308	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	6,634,637	13,427,192	20,061,829	0	20,061,829	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/17/2016 4:59 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	-20,429	920,832	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	560,411	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	746,245	2,609,751	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,132,465	3,855,842	5.00
7.00	00700	OPERATION OF PLANT	-35,134	918,490	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	53,440	8.00
9.00	00900	HOUSEKEEPING	0	415,781	9.00
10.00	01000	DIETARY	0	100,640	10.00
11.00	01100	CAFETERIA	-84,885	337,011	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-7,419	659,900	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-162	101,481	14.00
15.00	01500	PHARMACY	-108	673,067	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,284	78,698	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,076	1,088,395	30.00
43.00	04300	NURSERY	0	191,663	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-38,678	755,107	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	529,950	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-147,175	1,013,433	54.00
60.00	06000	LABORATORY	-1,893	1,239,210	60.00
65.00	06500	RESPIRATORY THERAPY	-753	261,066	65.00
66.00	06600	PHYSICAL THERAPY	-2,034	548,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	-29,345	233,159	67.00
68.00	06800	SPEECH PATHOLOGY	0	79,113	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,644	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-882	1,967,006	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-776,477	19,274,266	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	778	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	129,705	140,013	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-646,772	19,415,057	200.00

RECLASSIFICATIONS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/17/2016 4:59 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	0	421,896	1.00
	TOTALS		0	421,896	
	B - NURSEY AND L&D RECLASS				
1.00	NURSERY	43.00	137,425	54,238	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	379,982	149,968	2.00
	TOTALS		517,407	204,206	
	C - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	267	1.00
	TOTALS		0	267	
	D - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	35,096	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
	TOTALS		0	35,096	
500.00	Grand Total: Increases		517,407	661,465	500.00

RECLASSIFICATIONS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 Date/Time Prepared: 11/17/2016 4:59 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	421,896	0		1.00
	TOTALS		0	421,896			
	B - NURSEY AND L&D RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	517,407	204,206	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		517,407	204,206			
	C - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	267	9		1.00
	TOTALS		0	267			
	D - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	6,497	0		1.00
2.00	OPERATING ROOM	50.00	0	11,829	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	1,390	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	976	0		4.00
5.00	EMERGENCY	91.00	0	14,404	0		5.00
	TOTALS		0	35,096			
500.00	Grand Total: Decreases		517,407	661,465			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I Date/Time Prepared: 11/17/2016 4:59 pm

		Beginning Balances	Acquisitions Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	160,146	0	0	0	0	1.00
2.00	Land Improvements	66,241	0	0	0	0	2.00
3.00	Buildings and Fixtures	2,093,436	0	0	0	14,821	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	740,327	94,643	0	94,643	0	5.00
6.00	Movable Equipment	5,062,724	0	0	0	186,216	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,122,874	94,643	0	94,643	201,037	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,122,874	94,643	0	94,643	201,037	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	160,146	0	1.00
2.00	Land Improvements	66,241	0	2.00
3.00	Buildings and Fixtures	2,078,615	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	834,970	0	5.00
6.00	Movable Equipment	4,876,508	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,016,480	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	8,016,480	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/17/2016 4:59 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	141,938	751,100	15,034	19,307	14,149	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	228,620	331,476	0	315	0	2.00
3.00	Total (sum of lines 1-2)	370,558	1,082,576	15,034	19,622	14,149	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	941,528	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	560,411	2.00
3.00	Total (sum of lines 1-2)	0	1,501,939	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/17/2016 4:59 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,139,972	0	3,139,972	0.391690	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,876,508	0	4,876,508	0.608310	0	2.00
3.00	Total (sum of lines 1-2)	8,016,480	0	8,016,480	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	136,009	751,100	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	228,620	331,476	2.00
3.00	Total (sum of lines 1-2)	0	0	0	364,629	1,082,576	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	267	19,307	14,149	0	920,832	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	315	0	0	560,411	2.00
3.00	Total (sum of lines 1-2)	267	19,622	14,149	0	1,481,243	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/17/2016 4:59 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	-13,693	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-248	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,361	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	-171,299			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	143,451			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-84,885	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	-7,890	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	-29,262	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-1,044	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISC INCOME	B	-7,005	NURSING ADMINISTRATION	13.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/17/2016 4:59 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISC INCOME	B	-1,880	PHYSICAL THERAPY	66.00	0	33.02
33.03	LATE/PENALTY FEES	A	-162	CENTRAL SERVICES & SUPPLY	14.00	0	33.03
33.04	NON-ALLOWABLE EXPENSE	A	-34	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	NON-ALLOWABLE EXPENSE	A	-414	NURSING ADMINISTRATION	13.00	0	33.05
33.06	PROVIDER TAX ADJ	A	-461,033	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PROVIDER TAX ADJ	A	-10,394	MEDICAL RECORDS & LIBRARY	16.00	0	33.07
33.08	LOBBYING	A	-934	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LOSS ON SALE OF PPE	A	-178	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PHYSICIAN SUPPORT SERVICES	A	-5,662	CAP REL COSTS-BLDG & FIXT	1.00	9	33.10
33.11	PHYSICIAN SUPPORT SERVICES	A	-747	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PHYSICIAN RECRUITMENT FEES	A	-401	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	INCENTIVE ACCRUAL ADJUSTMENT	A	199,317	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	INCENTIVE ACCRUAL ADJUSTMENT	A	-185,014	ADMINISTRATIVE & GENERAL	5.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-646,772				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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/17/2016 4:59 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,321,156	1,803,969	2.00
3.00	194.02	OTHER NONREIMBURSABLE - MARK	HOME OFFICE	129,705	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	437,602	437,602	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	1,623,034	1,623,034	4.01
4.02	9.00	HOUSEKEEPING	SVH CHARGEBACKS	-78,914	-78,914	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	SVH CHARGEBACKS	85,603	85,603	4.03
4.04	15.00	PHARMACY	SVH CHARGEBACKS	13,229	13,229	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACKS	86,208	86,208	4.05
4.06	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	100	100	4.06
4.07	50.00	OPERATING ROOM	SVH CHARGEBACKS	175	175	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	33,378	33,378	4.08
4.09	65.00	RESPIRATORY THERAPY	SVH CHARGEBACKS	71,922	71,922	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF INSURANCE	964,698	645,984	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	13,693	14,767	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	248	267	4.12
4.13	7.00	OPERATION OF PLANT	TRIMEDX	486,691	514,464	4.13
4.14	15.00	PHARMACY	TRIMEDX	1,885	1,993	4.14
4.15	30.00	ADULTS & PEDIATRICS	TRIMEDX	53,908	56,984	4.15
4.16	50.00	OPERATING ROOM	TRIMEDX	73,135	77,308	4.16
4.17	54.00	RADIOLOGY-DIAGNOSTIC	TRIMEDX	181,918	192,299	4.17
4.18	60.00	LABORATORY	TRIMEDX	33,174	35,067	4.18
4.19	65.00	RESPIRATORY THERAPY	TRIMEDX	13,194	13,947	4.19
4.20	66.00	PHYSICAL THERAPY	TRIMEDX	2,695	2,849	4.20
4.21	67.00	OCCUPATIONAL THERAPY	TRIMEDX	1,451	1,534	4.21
4.22	91.00	EMERGENCY	TRIMEDX	15,456	16,338	4.22
4.23	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	226,541	-1,673	4.23
4.24	0.00			0	0	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,791,885	5,648,434	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office: Name	Related Organization(s) and/or Home Office: 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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	G		0.00	ST. VINCENT HEA	100.00	6.00
7.00	B		0.00	ST. VINCENT HOS	100.00	7.00
8.00	G		0.00	ASCENSION	100.00	8.00
9.00	A		0.00	TRIMEDX	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/17/2016 4:59 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	-482,813	0	2.00
3.00	129,705	0	3.00
4.00	0	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	318,714	0	4.10
4.11	-1,074	11	4.11
4.12	-19	0	4.12
4.13	-27,773	0	4.13
4.14	-108	0	4.14
4.15	-3,076	0	4.15
4.16	-4,173	0	4.16
4.17	-10,381	0	4.17
4.18	-1,893	0	4.18
4.19	-753	0	4.19
4.20	-154	0	4.20
4.21	-83	0	4.21
4.22	-882	0	4.22
4.23	228,214	0	4.23
4.24	0	0	4.24
5.00	143,451		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.

	Type of Business		
6.00	ADMINISTRATION		6.00
7.00	HOSPITAL		7.00
8.00	ADMINISTRATION		8.00
9.00	TECHNOLOGY MGMT		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/17/2016 4:59 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	50.00	OPERATING ROOM	34,505	34,505	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	136,794	136,794	0	0	0	2.00
3.00	91.00	EMERGENCY	694,139	0	694,139	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			865,438	171,299	694,139		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	34,505		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	136,794		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	171,299		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/17/2016 4:59 pm

Physical Therapy | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	333	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.21	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	5,628.00	1,111.00	2,876.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.63	51.76	25.58	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.82	39.82	25.88			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	448,158	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	57,505	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	505,663	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	73,568	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	579,231	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	579,231	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	13,260	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	13,260	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,735	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	14,995	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	14,995	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/17/2016 4:59 pm

Physical Therapy | Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.63	51.76	25.58	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	579,231	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	14,995	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	594,226	63.00
64.00	Total cost of outside supplier services (from your records)	532,723	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,260	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,735	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	14,995	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,735	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,735	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/17/2016 4:59 pm

Occupational Therapy | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	236	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.21	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,688.00	1,644.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.48	52.08	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.74	37.74	26.04			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	127,410	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	85,620	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	213,030	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	213,030	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	213,030	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	8,907	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	8,907	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,230	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	10,137	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	10,137	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/17/2016 4:59 pm

Occupational Therapy | Cost

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.48	52.08	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	213,030	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	10,137	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	223,167	63.00
64.00	Total cost of outside supplier services (from your records)	252,429	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	29,262	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	8,907	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,230	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,137	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,230	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,230	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 4:59 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	920,832	920,832				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	560,411		560,411			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,609,751	9,528	7,861	2,627,140		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,855,842	86,071	71,015	727,793	4,740,721	5.00
7.00	00700	OPERATION OF PLANT	918,490	94,620	78,069	0	1,091,179	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	53,440	7,186	5,929	0	66,555	8.00
9.00	00900	HOUSEKEEPING	415,781	16,719	13,795	0	446,295	9.00
10.00	01000	DIETARY	100,640	22,755	18,774	0	142,169	10.00
11.00	01100	CAFETERIA	337,011	10,701	8,829	0	356,541	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	659,900	21,236	17,521	269,822	968,479	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101,481	30,781	25,396	28,783	186,441	14.00
15.00	01500	PHARMACY	673,067	15,851	13,078	116,885	818,881	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,698	17,951	14,811	14,151	125,611	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,088,395	142,673	117,716	380,503	1,729,287	30.00
43.00	04300	NURSERY	191,663	2,871	2,369	56,172	253,075	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	755,107	60,296	49,748	157,063	1,022,214	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	529,950	12,571	10,372	155,315	708,208	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,013,433	42,155	34,781	251,471	1,341,840	54.00
60.00	06000	LABORATORY	1,239,210	17,922	14,787	0	1,271,919	60.00
65.00	06500	RESPIRATORY THERAPY	261,066	8,872	7,320	64,839	342,097	65.00
66.00	06600	PHYSICAL THERAPY	548,540	17,830	14,711	0	581,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	233,159	1,076	888	0	235,123	67.00
68.00	06800	SPEECH PATHOLOGY	79,113	3,331	2,749	35,644	120,837	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,644	0	0	0	55,644	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,636	0	0	0	26,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,967,006	29,676	24,485	368,699	2,389,866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,274,266	672,672	555,004	2,627,140	19,020,699	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,118	2,573	0	5,691	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	778	3,435	2,834	0	7,047	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	140,013	0	0	0	140,013	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	241,607	0	0	241,607	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,415,057	920,832	560,411	2,627,140	19,415,057	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/17/2016 4:59 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,740,721					5.00
7.00	00700	OPERATION OF PLANT	352,518	1,443,697				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,501	14,200	102,256			8.00
9.00	00900	HOUSEKEEPING	144,181	33,038	0	623,514		9.00
10.00	01000	DIETARY	45,929	44,963	3,065	29,702	265,828	10.00
11.00	01100	CAFETERIA	115,185	21,146	0	13,969	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	312,879	41,962	0	27,720	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,232	60,823	1,019	40,179	0	14.00
15.00	01500	PHARMACY	264,549	31,321	0	20,690	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,580	35,471	0	23,431	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	558,667	281,923	36,815	186,236	265,828	30.00
43.00	04300	NURSERY	81,759	5,673	0	3,748	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	330,238	119,145	9,203	78,705	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,795	24,841	0	16,409	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	433,498	83,299	0	55,026	0	54.00
60.00	06000	LABORATORY	410,909	35,414	0	23,394	0	60.00
65.00	06500	RESPIRATORY THERAPY	110,519	17,531	0	11,580	0	65.00
66.00	06600	PHYSICAL THERAPY	187,725	35,232	18,347	23,274	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,959	2,126	5,171	1,404	0	67.00
68.00	06800	SPEECH PATHOLOGY	39,038	6,583	0	4,348	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,976	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,605	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	772,076	58,640	15,341	38,737	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,613,318	953,331	88,961	598,552	265,828	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,839	6,162	0	4,070	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	13,295	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	2,277	6,787	0	4,483	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	45,233	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	78,054	477,417	0	16,409	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,740,721	1,443,697	102,256	623,514	265,828	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 4:59 pm

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	506,841					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	57,435	0	1,408,475			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,102	0	0	364,796		14.00
15.00	01500	PHARMACY	24,497	0	0	1,284	1,161,222	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,297	0	0	5	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,268	0	407,867	36,547	0	30.00
43.00	04300	NURSERY	14,170	0	49,708	6,223	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,479	0	134,981	83,358	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,177	0	137,429	17,206	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,559	0	229,977	6,740	0	54.00
60.00	06000	LABORATORY	0	0	0	76	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,424	0	54,106	12,935	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,082	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,893	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,857	0	24,054	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,765	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,903	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,161,222	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	105,576	0	370,353	128,779	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)	506,841	0	1,408,475	364,796	1,161,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	506,841	0	1,408,475	364,796	1,161,222	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/17/2016 4:59 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	232,395					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,812	3,631,250	0	3,631,250		30.00
43.00	04300	NURSERY	1,450	415,806	0	415,806		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,385	1,833,708	0	1,833,708		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,011	1,176,076	0	1,176,076		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,469	2,272,408	0	2,272,408		54.00
60.00	06000	LABORATORY	37,502	1,779,214	0	1,779,214		60.00
65.00	06500	RESPIRATORY THERAPY	5,487	569,679	0	569,679		65.00
66.00	06600	PHYSICAL THERAPY	12,620	867,361	0	867,361		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,814	330,490	0	330,490		67.00
68.00	06800	SPEECH PATHOLOGY	1,324	203,041	0	203,041		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	99,385	0	99,385		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,144	0	67,144		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,161,222	0	1,161,222		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	78,521	3,957,889	0	3,957,889		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)	232,395	18,364,673	0	18,364,673		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,762	0	17,762		190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	13,295	0	13,295		194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	20,594	0	20,594		194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	185,246	0	185,246		194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	813,487	0	813,487		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	232,395	19,415,057	0	19,415,057		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 4:59 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,528	7,861	17,389	17,389	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	325,796	86,071	71,015	482,882	4,819	5.00
7.00	00700	OPERATION OF PLANT	0	94,620	78,069	172,689	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,186	5,929	13,115	0	8.00
9.00	00900	HOUSEKEEPING	0	16,719	13,795	30,514	0	9.00
10.00	01000	DIETARY	0	22,755	18,774	41,529	0	10.00
11.00	01100	CAFETERIA	0	10,701	8,829	19,530	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	21,236	17,521	38,757	1,786	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,781	25,396	56,177	190	14.00
15.00	01500	PHARMACY	0	15,851	13,078	28,929	774	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,951	14,811	32,762	94	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	142,673	117,716	260,389	2,518	30.00
43.00	04300	NURSERY	0	2,871	2,369	5,240	372	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	60,296	49,748	110,044	1,039	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,571	10,372	22,943	1,028	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	42,155	34,781	76,936	1,664	54.00
60.00	06000	LABORATORY	0	17,922	14,787	32,709	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,872	7,320	16,192	429	65.00
66.00	06600	PHYSICAL THERAPY	0	17,830	14,711	32,541	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,076	888	1,964	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,331	2,749	6,080	236	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	29,676	24,485	54,161	2,440	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)	325,796	672,672	555,004	1,553,472	17,389	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,118	2,573	5,691	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	3,435	2,834	6,269	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	241,607	0	241,607	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	325,796	920,832	560,411	1,807,039	17,389	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/17/2016 4:59 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	487,701					5.00
7.00	00700	OPERATION OF PLANT	36,265	208,954				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,212	2,055	17,382			8.00
9.00	00900	HOUSEKEEPING	14,833	4,782	0	50,129		9.00
10.00	01000	DIETARY	4,725	6,508	521	2,388	55,671	10.00
11.00	01100	CAFETERIA	11,850	3,061	0	1,123	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	32,187	6,073	0	2,229	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,196	8,803	173	3,230	0	14.00
15.00	01500	PHARMACY	27,216	4,533	0	1,663	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,175	5,134	0	1,884	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,473	40,804	6,258	14,974	55,671	30.00
43.00	04300	NURSERY	8,411	821	0	301	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,973	17,244	1,564	6,328	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,537	3,595	0	1,319	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,596	12,056	0	4,424	0	54.00
60.00	06000	LABORATORY	42,272	5,126	0	1,881	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,370	2,537	0	931	0	65.00
66.00	06600	PHYSICAL THERAPY	19,312	5,099	3,119	1,871	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,814	308	879	113	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,016	953	0	350	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,849	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	885	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	79,428	8,487	2,608	3,114	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)	474,595	137,979	15,122	48,123	55,671	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	189	892	0	327	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	2,260	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	234	982	0	360	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	4,653	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	8,030	69,101	0	1,319	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	487,701	208,954	17,382	50,129	55,671	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 4:59 pm

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	35,564					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	4,030	0	85,062			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,130	0	0	75,899		14.00
15.00	01500	PHARMACY	1,719	0	0	267	65,101	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	512	0	0	1	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,159	0	24,631	7,604	0	30.00
43.00	04300	NURSERY	994	0	3,002	1,295	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,700	0	8,152	17,343	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,749	0	8,300	3,580	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,600	0	13,889	1,402	0	54.00
60.00	06000	LABORATORY	0	0	0	16	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,082	0	3,268	2,691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,890	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,018	0	67.00
68.00	06800	SPEECH PATHOLOGY	481	0	1,453	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,361	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,638	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	65,101	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,408	0	22,367	26,793	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)	35,564	0	85,062	75,899	65,101	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	35,564	0	85,062	75,899	65,101	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/17/2016 4:59 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,562					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,266	480,747	0	480,747		30.00
43.00	04300	NURSERY	278	20,714	0	20,714		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,335	201,722	0	201,722		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	769	67,820	0	67,820		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,833	170,400	0	170,400		54.00
60.00	06000	LABORATORY	7,194	89,198	0	89,198		60.00
65.00	06500	RESPIRATORY THERAPY	1,053	39,553	0	39,553		65.00
66.00	06600	PHYSICAL THERAPY	2,421	66,253	0	66,253		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,115	13,211	0	13,211		67.00
68.00	06800	SPEECH PATHOLOGY	254	13,823	0	13,823		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,210	0	7,210		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,523	0	7,523		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	65,101	0	65,101		73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	15,044	221,850	0	221,850		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)	44,562	1,465,125	0	1,465,125		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,099	0	7,099		190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	2,260	0	2,260		194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	7,845	0	7,845		194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	4,653	0	4,653		194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	320,057	0	320,057		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	44,562	1,807,039	0	1,807,039		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/17/2016 4:59 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	160,050					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		118,056				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,656	1,656	6,427,369			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,960	14,960	1,780,570	-4,740,721	14,674,336	5.00
7.00	00700	OPERATION OF PLANT	16,446	16,446	0	0	1,091,179	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,249	1,249	0	0	66,555	8.00
9.00	00900	HOUSEKEEPING	2,906	2,906	0	0	446,295	9.00
10.00	01000	DIETARY	3,955	3,955	0	0	142,169	10.00
11.00	01100	CAFETERIA	1,860	1,860	0	0	356,541	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,691	3,691	660,126	0	968,479	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,350	5,350	70,418	0	186,441	14.00
15.00	01500	PHARMACY	2,755	2,755	285,963	0	818,881	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,120	3,120	34,620	0	125,611	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,798	24,798	930,909	0	1,729,287	30.00
43.00	04300	NURSERY	499	499	137,425	0	253,075	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,480	10,480	384,259	0	1,022,214	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,185	2,185	379,982	0	708,208	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,327	7,327	615,230	0	1,341,840	54.00
60.00	06000	LABORATORY	3,115	3,115	0	0	1,271,919	60.00
65.00	06500	RESPIRATORY THERAPY	1,542	1,542	158,631	0	342,097	65.00
66.00	06600	PHYSICAL THERAPY	3,099	3,099	0	0	581,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	187	187	0	0	235,123	67.00
68.00	06800	SPEECH PATHOLOGY	579	579	87,204	0	120,837	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	55,644	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	26,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,158	5,158	902,032	0	2,389,866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,917	116,917	6,427,369	-4,740,721	14,279,978	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	542	0	0	5,691	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	597	597	0	0	7,047	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	140,013	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	41,994	0	0	0	241,607	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	920,832	560,411	2,627,140		4,740,721	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.753402	4.746993	0.408743		0.323062	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			17,389		487,701	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002705		0.033235	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/17/2016 4:59 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	126,988					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,249	13,744				8.00
9.00	00900	HOUSEKEEPING	2,906	0	83,024			9.00
10.00	01000	DIETARY	3,955	412	3,955	7,378		10.00
11.00	01100	CAFETERIA	1,860	0	1,860	0	153,230	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,691	0	3,691	0	17,364	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,350	137	5,350	0	4,868	14.00
15.00	01500	PHARMACY	2,755	0	2,755	0	7,406	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,120	0	3,120	0	2,206	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,798	4,948	24,798	7,378	35,151	30.00
43.00	04300	NURSERY	499	0	499	0	4,284	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,480	1,237	10,480	0	11,633	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,185	0	2,185	0	11,844	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,327	0	7,327	0	19,820	54.00
60.00	06000	LABORATORY	3,115	0	3,115	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,542	0	1,542	0	4,663	65.00
66.00	06600	PHYSICAL THERAPY	3,099	2,466	3,099	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	187	695	187	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	579	0	579	0	2,073	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,158	2,062	5,158	0	31,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	83,855	11,957	79,700	7,378	153,230	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	0	542	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	1,787	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	597	0	597	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	41,994	0	2,185	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,443,697	102,256	623,514	265,828	506,841	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.368767	7.440047	7.510045	36.029818	3.307714	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	208,954	17,382	50,129	55,671	35,564	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.645463	1.264697	0.603789	7.545541	0.232096	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/17/2016 4:59 pm

		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			12.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	121,386				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	290,933			14.00
15.00	01500	PHARMACY	0	0	1,024	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	4	0	60,081,492	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	35,151	29,147	0	3,053,678	30.00
43.00	04300	NURSERY	0	4,284	4,963	0	374,982	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,633	66,480	0	4,494,580	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,844	13,722	0	1,036,960	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,820	5,375	0	14,599,064	54.00
60.00	06000	LABORATORY	0	0	61	0	9,695,568	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,663	10,316	0	1,418,596	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,243	0	3,262,683	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,902	0	1,503,141	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,073	0	0	342,238	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	20,548	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	25,443	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	31,918	102,705	0	20,300,002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	121,386	290,933	1,000	60,081,492	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE - LEASED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,408,475	364,796	1,161,222	232,395	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	11.603274	1.253883	1,161.222000	0.003868	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	85,062	75,899	65,101	44,562	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.700756	0.260881	65.101000	0.000742	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/17/2016 4:59 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	3,631,250		3,631,250	0	0	30.00
43.00	04300	NURSERY	415,806		415,806	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,833,708		1,833,708	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,076		1,176,076	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,272,408		2,272,408	0	0	54.00
60.00	06000	LABORATORY	1,779,214		1,779,214	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	569,679	0	569,679	0	0	65.00
66.00	06600	PHYSICAL THERAPY	867,361	0	867,361	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,490	0	330,490	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	203,041	0	203,041	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,385		99,385	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,144		67,144	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,161,222		1,161,222	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,957,889		3,957,889	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	319,260		319,260		0	92.00
200.00		Subtotal (see instructions)	18,683,933	0	18,683,933	0	0	200.00
201.00		Less Observation Beds	319,260		319,260		0	201.00
202.00		Total (see instructions)	18,364,673	0	18,364,673	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,814,621		2,814,621			30.00
43.00	04300	NURSERY	374,982		374,982			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	851,961	3,642,619	4,494,580	0.407982	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	703,446	333,514	1,036,960	1.134158	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	590,940	14,008,124	14,599,064	0.155654	0.000000	54.00
60.00	06000	LABORATORY	660,176	9,035,392	9,695,568	0.183508	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	475,660	942,936	1,418,596	0.401579	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	663,806	2,598,877	3,262,683	0.265843	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	679,739	823,402	1,503,141	0.219866	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	86,607	255,631	342,238	0.593274	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	455,135	598,636	1,053,771	0.094314	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,701	19,688	70,389	0.953899	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,208,762	2,494,485	4,703,247	0.246898	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	343,482	19,956,520	20,300,002	0.194970	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,012	224,045	239,057	1.335497	0.000000	92.00
200.00		Subtotal (see instructions)	10,975,030	54,933,869	65,908,899			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,975,030	54,933,869	65,908,899			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/17/2016 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/17/2016 4:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,631,250		3,631,250	0	3,631,250	30.00
43.00	04300	NURSERY	415,806		415,806	0	415,806	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,833,708		1,833,708	0	1,833,708	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,076		1,176,076	0	1,176,076	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,272,408		2,272,408	0	2,272,408	54.00
60.00	06000	LABORATORY	1,779,214		1,779,214	0	1,779,214	60.00
65.00	06500	RESPIRATORY THERAPY	569,679	0	569,679	0	569,679	65.00
66.00	06600	PHYSICAL THERAPY	867,361	0	867,361	0	867,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,490	0	330,490	0	330,490	67.00
68.00	06800	SPEECH PATHOLOGY	203,041	0	203,041	0	203,041	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,385		99,385	0	99,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,144		67,144	0	67,144	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,161,222		1,161,222	0	1,161,222	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,957,889		3,957,889	0	3,957,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	319,260		319,260		319,260	92.00
200.00		Subtotal (see instructions)	18,683,933	0	18,683,933	0	18,683,933	200.00
201.00		Less Observation Beds	319,260		319,260		319,260	201.00
202.00		Total (see instructions)	18,364,673	0	18,364,673	0	18,364,673	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/17/2016 4:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,814,621		2,814,621			30.00
43.00	04300	NURSERY	374,982		374,982			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	851,961	3,642,619	4,494,580	0.407982	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	703,446	333,514	1,036,960	1.134158	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	590,940	14,008,124	14,599,064	0.155654	0.000000	54.00
60.00	06000	LABORATORY	660,176	9,035,392	9,695,568	0.183508	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	475,660	942,936	1,418,596	0.401579	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	663,806	2,598,877	3,262,683	0.265843	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	679,739	823,402	1,503,141	0.219866	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	86,607	255,631	342,238	0.593274	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	455,135	598,636	1,053,771	0.094314	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,701	19,688	70,389	0.953899	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,208,762	2,494,485	4,703,247	0.246898	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	343,482	19,956,520	20,300,002	0.194970	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,012	224,045	239,057	1.335497	0.000000	92.00
200.00		Subtotal (see instructions)	10,975,030	54,933,869	65,908,899			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,975,030	54,933,869	65,908,899			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/17/2016 4:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II Date/Time Prepared: 11/17/2016 4:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,833,708	201,722	1,631,986	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,076	67,820	1,108,256	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,272,408	170,400	2,102,008	0	0	54.00
60.00	06000	LABORATORY	1,779,214	89,198	1,690,016	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	569,679	39,553	530,126	0	0	65.00
66.00	06600	PHYSICAL THERAPY	867,361	66,253	801,108	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,490	13,211	317,279	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	203,041	13,823	189,218	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,385	7,210	92,175	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,144	7,523	59,621	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,161,222	65,101	1,096,121	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,957,889	221,850	3,736,039	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	319,260	42,267	276,993	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	14,636,877	1,005,931	13,630,946	0	0	200.00
201.00		Less Observation Beds	319,260	42,267	276,993	0	0	201.00
202.00		Total (line 200 minus line 201)	14,317,617	963,664	13,353,953	0	0	202.00

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

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II | Date/Time Prepared: 11/17/2016 4:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,833,708	4,494,580	0.407982	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,076	1,036,960	1.134158	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,272,408	14,599,064	0.155654	54.00
60.00	06000	LABORATORY	1,779,214	9,695,568	0.183508	60.00
65.00	06500	RESPIRATORY THERAPY	569,679	1,418,596	0.401579	65.00
66.00	06600	PHYSICAL THERAPY	867,361	3,262,683	0.265843	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,490	1,503,141	0.219866	67.00
68.00	06800	SPEECH PATHOLOGY	203,041	342,238	0.593274	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,385	1,053,771	0.094314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,144	70,389	0.953899	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,161,222	4,703,247	0.246898	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	3,957,889	20,300,002	0.194970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	319,260	239,057	1.335497	92.00
200.00		Subtotal (sum of lines 50 thru 199)	14,636,877	62,719,296		200.00
201.00		Less Observation Beds	319,260	0		201.00
202.00		Total (line 200 minus line 201)	14,317,617	62,719,296		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/17/2016 4:59 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	201,722	4,494,580	0.044881	70,285	3,154	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	67,820	1,036,960	0.065403	2,947	193	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,400	14,599,064	0.011672	204,863	2,391	54.00
60.00	06000	LABORATORY	89,198	9,695,568	0.009200	232,095	2,135	60.00
65.00	06500	RESPIRATORY THERAPY	39,553	1,418,596	0.027882	379,121	10,571	65.00
66.00	06600	PHYSICAL THERAPY	66,253	3,262,683	0.020306	153,169	3,110	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,211	1,503,141	0.008789	164,311	1,444	67.00
68.00	06800	SPEECH PATHOLOGY	13,823	342,238	0.040390	37,555	1,517	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,210	1,053,771	0.006842	204,634	1,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,523	70,389	0.106877	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,101	4,703,247	0.013842	1,028,317	14,234	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	221,850	20,300,002	0.010929	2,879	31	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	42,267	239,057	0.176807	624	110	92.00
200.00		Total (lines 50-199)	1,005,931	62,719,296		2,480,800	40,290	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/17/2016 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 4:59 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	4,494,580	0.000000	0.000000	70,285	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,036,960	0.000000	0.000000	2,947	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,599,064	0.000000	0.000000	204,863	54.00
60.00	06000	LABORATORY	0	9,695,568	0.000000	0.000000	232,095	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,418,596	0.000000	0.000000	379,121	65.00
66.00	06600	PHYSICAL THERAPY	0	3,262,683	0.000000	0.000000	153,169	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,503,141	0.000000	0.000000	164,311	67.00
68.00	06800	SPEECH PATHOLOGY	0	342,238	0.000000	0.000000	37,555	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,053,771	0.000000	0.000000	204,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	70,389	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,703,247	0.000000	0.000000	1,028,317	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	20,300,002	0.000000	0.000000	2,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	239,057	0.000000	0.000000	624	92.00
200.00		Total (lines 50-199)	0	62,719,296			2,480,800	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/17/2016 4:59 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/17/2016 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.407982	0	1,167,855	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.134158	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155654	0	3,943,742	0	0	54.00
60.00	06000	LABORATORY	0.183508	0	2,686,713	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.401579	0	531,551	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.265843	0	918,216	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219866	0	289,464	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.593274	0	16,522	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.094314	0	226,954	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.953899	0	2,950	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246898	0	1,315,450	9,455	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.194970	0	4,562,420	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.335497	0	75,589	0	0	92.00
200.00		Subtotal (see instructions)		0	15,737,426	9,455	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	15,737,426	9,455	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/17/2016 4:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	476,464	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	613,859	0	54.00
60.00	06000	LABORATORY	493,033	0	60.00
65.00	06500	RESPIRATORY THERAPY	213,460	0	65.00
66.00	06600	PHYSICAL THERAPY	244,101	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,643	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,802	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,405	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,814	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	324,782	2,334	73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	889,535	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	100,949	0	92.00
200.00		Subtotal (see instructions)	3,453,847	2,334	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,453,847	2,334	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151316 | Component CCN: 15Z316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/17/2016 4:59 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	0.407982	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.134158	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155654	0	0	0	0	54.00
60.00	06000	LABORATORY	0.183508	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.401579	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.265843	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219866	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.593274	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.094314	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.953899	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246898	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.194970	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.335497	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: 151316 | Component CCN: 15Z316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/17/2016 4:59 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/17/2016 4:59 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	480,747	134,923	345,824	1,800	192.12	30.00
43.00	NURSERY	20,714		20,714	237	87.40	43.00
200.00	Total (lines 30-199)	501,461		366,538	2,037		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	14	2,690	30.00
43.00	NURSERY	69	6,031	43.00
200.00	Total (lines 30-199)	83	8,721	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/17/2016 4:59 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	201,722	4,494,580	0.044881	86,352	3,876	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	67,820	1,036,960	0.065403	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,400	14,599,064	0.011672	40,377	471	54.00
60.00	06000	LABORATORY	89,198	9,695,568	0.009200	54,982	506	60.00
65.00	06500	RESPIRATORY THERAPY	39,553	1,418,596	0.027882	4,826	135	65.00
66.00	06600	PHYSICAL THERAPY	66,253	3,262,683	0.020306	585	12	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,211	1,503,141	0.008789	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,823	342,238	0.040390	684	28	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,210	1,053,771	0.006842	10,105	69	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,523	70,389	0.106877	1,126	120	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,101	4,703,247	0.013842	39,600	548	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	221,850	20,300,002	0.010929	34,901	381	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	42,267	239,057	0.176807	0	0	92.00
200.00		Total (lines 50-199)	1,005,931	62,719,296		273,538	6,146	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part III Date/Time Prepared: 11/17/2016 4:59 pm
	Title XIX	Hospital	Cost

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,800	0.00	14	0	30.00
43.00	04300	NURSERY	237	0.00	69	0	43.00
200.00		Total (lines 30-199)	2,037		83	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/17/2016 4:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/17/2016 4:59 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	4,494,580	0.000000	0.000000	86,352	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,036,960	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,599,064	0.000000	0.000000	40,377	54.00
60.00	06000	LABORATORY	0	9,695,568	0.000000	0.000000	54,982	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,418,596	0.000000	0.000000	4,826	65.00
66.00	06600	PHYSICAL THERAPY	0	3,262,683	0.000000	0.000000	585	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,503,141	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	342,238	0.000000	0.000000	684	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,053,771	0.000000	0.000000	10,105	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	70,389	0.000000	0.000000	1,126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,703,247	0.000000	0.000000	39,600	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	20,300,002	0.000000	0.000000	34,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	239,057	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	62,719,296			273,538	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/17/2016 4:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 4:59 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)	2,515	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,800	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,580	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	350	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)	351	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	7	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	891	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)	348	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)	349	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	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.09	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,631,250	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)	904	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)	939	25.00
26.00	Total swing-bed cost (see instructions)	1,019,120	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,612,130	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,612,130	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)	1,451.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,293,001	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)	1,293,001	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 4:59 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)	632,451	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,925,452	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)	505,011	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	506,462	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,011,473	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)	220	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,451.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	319,260	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 4:59 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	480,747	3,631,250	0.132392	319,260	42,267	90.00
91.00	Nursing School cost	0	3,631,250	0.000000	319,260	0	91.00
92.00	Allied health cost	0	3,631,250	0.000000	319,260	0	92.00
93.00	All other Medical Education	0	3,631,250	0.000000	319,260	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/17/2016 4:59 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)	2,515	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,800	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,580	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	350	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)	351	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	7	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	14	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)	237	15.00
16.00	Nursery days (title V or XIX only)	69	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	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.09	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,631,250	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)	904	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)	939	25.00
26.00	Total swing-bed cost (see instructions)	1,019,120	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,612,130	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,612,130	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)	1,451.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	20,317	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)	20,317	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 4:59 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)	415,806	237	1,754.46	69	121,058	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)	72,714	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	214,089	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)	220	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,451.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	319,260	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/17/2016 4:59 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	480,747	3,631,250	0.132392	319,260	42,267	90.00
91.00	Nursing School cost	0	3,631,250	0.000000	319,260	0	91.00
92.00	Allied health cost	0	3,631,250	0.000000	319,260	0	92.00
93.00	All other Medical Education	0	3,631,250	0.000000	319,260	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/17/2016 4:59 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		1,117,748		30.00
43.00	04300	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.407982	70,285	28,675	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.134158	2,947	3,342	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155654	204,863	31,888	54.00
60.00	06000	LABORATORY	0.183508	232,095	42,591	60.00
65.00	06500	RESPIRATORY THERAPY	0.401579	379,121	152,247	65.00
66.00	06600	PHYSICAL THERAPY	0.265843	153,169	40,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219866	164,311	36,126	67.00
68.00	06800	SPEECH PATHOLOGY	0.593274	37,555	22,280	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.094314	204,634	19,300	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.953899	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246898	1,028,317	253,889	73.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.194970	2,879	561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.335497	624	833	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,480,800	632,451	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,480,800		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3

Component CCN: 15Z316 | Date/Time Prepared: 11/17/2016 4:59 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	0.407982	8,051	3,285	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.134158	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155654	35,980	5,600	54.00
60.00	06000	LABORATORY	0.183508	80,252	14,727	60.00
65.00	06500	RESPIRATORY THERAPY	0.401579	91,713	36,830	65.00
66.00	06600	PHYSICAL THERAPY	0.265843	454,928	120,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219866	469,033	103,124	67.00
68.00	06800	SPEECH PATHOLOGY	0.593274	34,483	20,458	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.094314	38,428	3,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.953899	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246898	334,331	82,546	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.194970	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.335497	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,547,199	391,133	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,547,199		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/17/2016 4:59 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		181,508		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.407982	86,352	35,230	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.134158	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155654	40,377	6,285	54.00
60.00	06000	LABORATORY	0.183508	54,982	10,090	60.00
65.00	06500	RESPIRATORY THERAPY	0.401579	4,826	1,938	65.00
66.00	06600	PHYSICAL THERAPY	0.265843	585	156	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219866	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.593274	684	406	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.094314	10,105	953	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.953899	1,126	1,074	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246898	39,600	9,777	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.194970	34,901	6,805	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.335497	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		273,538	72,714	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)		273,538		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/17/2016 4:59 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,456,181	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,456,181	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,490,743	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)	30,097	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,590,769	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)	869,877	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)	869,877	30.00
31.00	Primary payer payments	585	31.00
32.00	Subtotal (line 30 minus line 31)	869,292	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)	952,582	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	619,178	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	606,994	36.00
37.00	Subtotal (see instructions)	1,488,470	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,488,470	40.00
40.01	Sequestration adjustment (see instructions)	29,769	40.01
41.00	Interim payments	1,750,801	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-292,100	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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 11/17/2016 4:59 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,490,954		1,750,801	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/12/2016	51,400		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)		51,400		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,542,354		1,750,801	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		141,959		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		292,100	6.02
7.00	Total Medicare program liability (see instructions)		1,684,313		1,458,701	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: 151316 | Component CCN: 15Z316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2016 4:59 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		1,185,490		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)		1,185,490		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		197,523		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,383,013		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: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/17/2016 4:59 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	523	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	891	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	113	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,580	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	65,908,899	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,789,013	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151316 Component CCN: 15Z316	Period: From 07/01/2015 To 06/30/2016	Worksheet E-2 Date/Time Prepared: 11/17/2016 4:59 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)	1,021,588	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)	395,044	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	697	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)	1,416,632	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,416,632	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)	1,416,632	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,394	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)	1,411,238	0	15.00
16.00		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,411,238	0	19.00
19.01	Sequestration adjustment (see instructions)	28,225	0	19.01
20.00	Interim payments	1,185,490	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)	197,523	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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-3 Part V Date/Time Prepared: 11/17/2016 4:59 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,925,452	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,925,452	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,944,707	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,944,707	19.00
20.00	Deductibles (exclude professional component)	255,808	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,688,899	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,688,899	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	45,827	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	29,788	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,648	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,718,687	28.00
29.00		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,718,687	30.00
30.01	Sequestration adjustment (see instructions)	34,374	30.01
31.00	Interim payments	1,542,354	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)	141,959	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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-3 Part VII Date/Time Prepared: 11/17/2016 4:59 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	214,089		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)	214,089	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)	214,089	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	181,508		8.00
9.00	Ancillary service charges	273,538	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)	455,046	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)	455,046	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	240,957	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)	214,089	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)	214,089	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)	214,089	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)	214,089	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	214,089	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)	214,089	0	40.00
41.00	Interim payments	214,089	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: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G Date/Time Prepared: 11/17/2016 4:59 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	44,099,190	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	5,636,679	0	0	0	4.00
5.00	Other receivable	175,401	10,267	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,469,277	0	0	0	6.00
7.00	Inventory	372,774	0	0	0	7.00
8.00	Prepaid expenses	62,896	0	0	0	8.00
9.00	Other current assets	268,044	0	0	0	9.00
10.00	Due from other funds	-39,234	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	47,106,473	10,267	0	0	11.00
	FIXED ASSETS					
12.00	Land	160,146	0	0	0	12.00
13.00	Land improvements	66,241	0	0	0	13.00
14.00	Accumulated depreciation	-55,818	0	0	0	14.00
15.00	Buildings	2,078,615	0	0	0	15.00
16.00	Accumulated depreciation	-964,880	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	834,970	0	0	0	19.00
20.00	Accumulated depreciation	-553,119	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	4,876,508	0	0	0	23.00
24.00	Accumulated depreciation	-3,427,157	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)	3,015,506	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	14,097	39,234	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,097	39,234	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,136,076	49,501	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,064,602	0	0	0	37.00
38.00	Salaries, wages, and fees payable	617,688	0	0	0	38.00
39.00	Payroll taxes payable	194,641	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,540,812	10,267	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,417,743	10,267	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	473,234	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	473,234	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,890,977	10,267	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	46,245,099				52.00
53.00	Specific purpose fund		39,234			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)	46,245,099	39,234	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,136,076	49,501	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 Date/Time Prepared: 11/17/2016 4:59 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		47,725,661		29,319		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,157,270				2.00
3.00	Total (sum of line 1 and line 2)		48,882,931		29,319		3.00
4.00	TEMP RESTRICTED GRANT REVENUE	0		134,228		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		134,228		10.00
11.00	Subtotal (line 3 plus line 10)		48,882,931		163,547		11.00
12.00	CONTRIBUTIONS/DONATIONS/GRANTS	399,291		0		0	12.00
13.00	TRANSFER TO AFFILIATES	2,238,541		0		0	13.00
14.00	TEMP RESTRICTED REL OPERATIONS	0		124,313		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2,637,832		124,313		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		46,245,099		39,234		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	TEMP RESTRICTED GRANT REVENUE		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	CONTRIBUTIONS/DONATIONS/GRANTS		0		12.00
13.00	TRANSFER TO AFFILIATES		0		13.00
14.00	TEMP RESTRICTED REL OPERATIONS		0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151316 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/17/2016 4:59 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,335,831		4,335,831	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,335,831		4,335,831	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,335,831		4,335,831	17.00
18.00	Ancillary services	6,671,763	34,323,728	40,995,491	18.00
19.00	Outpatient services	363,858	20,213,719	20,577,577	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,371,452	54,537,447	65,908,899	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,061,829		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)		20,061,829		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151316	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/17/2016 4:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	65,908,899	1.00
2.00	Less contractual allowances and discounts on patients' accounts	43,873,538	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,035,361	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,061,829	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,973,532	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-1,288,137	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	84,885	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	7,890	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	163,407	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	125,357	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	8,885	24.01
24.02	BARBER AND BEAUTY	5,743	24.02
24.03	GAIN ON SALE OF ASSETS	76,200	24.03
25.00	Total other income (sum of lines 6-24)	-815,770	25.00
26.00	Total (line 5 plus line 25)	1,157,762	26.00
27.00	DONATIONS	492	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	492	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,157,270	29.00