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: 152020

Period:
From 07/01/2015
To 06/30/2016

Worksheet S
Parts I-III
Date/Time Prepared:
11/16/2016 4:56 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/16/2016 Time: 4:56 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 SETON SPECIALITY HOSPITAL (152020) 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		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-186,087	0	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-186,087	0	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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/16/2016 4:48 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8050 TOWNSHIP LINE ROAD	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	County: MARION	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 SETON SPECIALITY HOSPITAL	152020	26900	2	02/08/2003	N	P	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									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)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/16/2016 4:48 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/16/2016 4:48 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/16/2016 4:48 pm

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

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

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	Y	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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/16/2016 4:48 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		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.					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:	83,475	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.	N		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.	N		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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/16/2016 4:48 pm

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

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	N	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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		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: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/16/2016 4:48 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/16/2016 4:48 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	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.	RONALD	HELMS	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.	317-583-3234	RONALD.HELMS@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/16/2016 4:48 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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/16/2016 4:48 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	74	27,084	0.00	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)		74	27,084	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		74	27,084	0.00	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)		74				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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/16/2016 4:48 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)	10,912	1,403	21,246			1.00
2.00	HMO and other (see instructions)	2,490	0				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	10,912	1,403	21,246			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)	10,912	1,403	21,246	0.00	253.64	14.00
15.00	CAH visits	0	0	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)	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	253.64	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/16/2016 4:48 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	289	4	544	1.00
2.00	HMO and other (see instructions)			63	33		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	289	4	544	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/16/2016 4:48 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		948,209	948,209	-231	947,978	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		618,139	618,139	0	618,139	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	182,036	3,485,668	3,667,704	-34	3,667,670	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,375,695	3,429,932	5,805,627	5,245	5,810,872	5.00
7.00	00700	OPERATION OF PLANT	108,392	1,620,529	1,728,921	-6,343	1,722,578	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,361	66,361	0	66,361	8.00
9.00	00900	HOUSEKEEPING	0	503,584	503,584	0	503,584	9.00
10.00	01000	DIETARY	0	750,902	750,902	0	750,902	10.00
13.00	01300	NURSING ADMINISTRATION	1,057,859	216,216	1,274,075	-9,750	1,264,325	13.00
15.00	01500	PHARMACY	1,343,951	2,711,204	4,055,155	-71,502	3,983,653	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,725	135,070	168,795	0	168,795	16.00
17.00	01700	SOCIAL SERVICE	143,425	10,382	153,807	0	153,807	17.00
18.00	01851	PASTORAL CARE	72,478	1,200	73,678	0	73,678	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,533,957	3,075,945	10,609,902	-993,300	9,616,602	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	184,801	309,307	494,108	-111,877	382,231	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	164,621	106,816	271,437	-1,992	269,445	54.00
54.01	03630	ULTRA SOUND	75,499	8,636	84,135	0	84,135	54.01
57.00	05700	CT SCAN	151,863	16,271	168,134	-144	167,990	57.00
60.00	06000	LABORATORY	0	789,682	789,682	0	789,682	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	112,114	112,114	0	112,114	63.00
65.00	06500	RESPIRATORY THERAPY	2,139,266	580,575	2,719,841	-83,601	2,636,240	65.00
66.00	06600	PHYSICAL THERAPY	496,352	85,203	581,555	-6,780	574,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	261,131	31,027	292,158	-1,102	291,056	67.00
68.00	06800	SPEECH PATHOLOGY	158,754	14,187	172,941	-65	172,876	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	650	2,876	3,526	0	3,526	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,282,288	1,282,288	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
74.00	07400	RENAL DIALYSIS	0	673,359	673,359	-812	672,547	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,484,455	20,303,394	36,787,849	0	36,787,849	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	1,697	1,697	0	1,697	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	16,484,455	20,305,091	36,789,546	0	36,789,546	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/16/2016 4:48 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	-929	947,049	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,420	621,559	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	27,611	3,695,281	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	313,449	6,124,321	5.00
7.00	00700	OPERATION OF PLANT	-58,444	1,664,134	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,361	8.00
9.00	00900	HOUSEKEEPING	0	503,584	9.00
10.00	01000	DIETARY	-98,268	652,634	10.00
13.00	01300	NURSING ADMINISTRATION	0	1,264,325	13.00
15.00	01500	PHARMACY	0	3,983,653	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,354	166,441	16.00
17.00	01700	SOCIAL SERVICE	0	153,807	17.00
18.00	01851	PASTORAL CARE	0	73,678	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	9,616,602	30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	382,231	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	269,445	54.00
54.01	03630	ULTRA SOUND	0	84,135	54.01
57.00	05700	CT SCAN	0	167,990	57.00
60.00	06000	LABORATORY	0	789,682	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	112,114	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,636,240	65.00
66.00	06600	PHYSICAL THERAPY	-4,080	570,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	291,056	67.00
68.00	06800	SPEECH PATHOLOGY	0	172,876	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,526	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,282,288	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
74.00	07400	RENAL DIALYSIS	0	672,547	74.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	180,405	36,968,254	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	1,697	194.00
194.01	07951	MARKETING	158,754	158,754	194.01
200.00		TOTAL (SUM OF LINES 118-199)	339,159	37,128,705	200.00

RECLASSIFICATIONS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/16/2016 4:48 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUGS CHARGED TO PATIENTS				
1.00	PHARMACY	15.00	0	26,524	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	26,524	
	B - MEDICAL SUPPLIES CHARGED TO PATIENT				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,026	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,282,288	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	TOTALS		0	1,287,314	
	C - NON-CAPITAL INTEREST EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	231	1.00
	TOTALS		0	231	
500.00	Grand Total: Increases		0	1,314,069	500.00

RECLASSIFICATIONS

Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/16/2016 4:48 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	23,035	0		2.00
3.00	OPERATING ROOM	50.00	0	95	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,992	0		4.00
5.00	CT SCAN	57.00	0	144	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	434	0		6.00
7.00	RENAL DIALYSIS	74.00	0	812	0		7.00
	TOTALS		0	26,524			
	B - MEDICAL SUPPLIES CHARGED TO PATIENT						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34	0		1.00
2.00	OPERATION OF PLANT	7.00	0	6,343	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	9,750	0		3.00
4.00	PHARMACY	15.00	0	98,026	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	970,265	0		5.00
6.00	OPERATING ROOM	50.00	0	111,782	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	83,167	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	6,780	0		8.00
9.00	OCCUPATIONAL THERAPY	67.00	0	1,102	0		9.00
10.00	SPEECH PATHOLOGY	68.00	0	65	0		10.00
	TOTALS		0	1,287,314			
	C - NON-CAPITAL INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	231	11		1.00
	TOTALS		0	231			
500.00	Grand Total: Decreases		0	1,314,069			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/16/2016 4:48 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	847,629	0	0	0	0	1.00
2.00	Land Improvements	3,157	0	0	0	0	2.00
3.00	Buildings and Fixtures	15,901,287	44,850	0	44,850	0	3.00
4.00	Building Improvements	166,523	0	0	0	0	4.00
5.00	Fixed Equipment	982,593	0	0	0	0	5.00
6.00	Movable Equipment	4,838,917	264,688	0	264,688	144,573	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,740,106	309,538	0	309,538	144,573	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,740,106	309,538	0	309,538	144,573	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	847,629	0	1.00
2.00	Land Improvements	3,157	0	2.00
3.00	Buildings and Fixtures	15,946,137	0	3.00
4.00	Building Improvements	166,523	0	4.00
5.00	Fixed Equipment	982,593	0	5.00
6.00	Movable Equipment	4,959,032	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,905,071	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	22,905,071	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II Date/Time Prepared: 11/16/2016 4:48 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	765,449	161,815	13,006	7,939	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	344,667	260,228	0	4,777	5,047	2.00
3.00	Total (sum of lines 1-2)	1,110,116	422,043	13,006	12,716	5,047	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	948,209	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,420	618,139	2.00
3.00	Total (sum of lines 1-2)	3,420	1,566,348	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/16/2016 4:48 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	766,986	0	766,986	0.624314	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	461,540	0	461,540	0.375686	0	2.00
3.00	Total (sum of lines 1-2)	1,228,526	0	1,228,526	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	765,449	161,815	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	344,667	260,228	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,110,116	422,043	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	11,846	7,939	0	0	947,049	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,777	5,047	6,840	621,559	2.00
3.00	Total (sum of lines 1-2)	11,846	12,716	5,047	6,840	1,568,608	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/16/2016 4:48 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	813,695			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-98,268	DIETARY	10.00	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	-2,354	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)	A	-206	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-4,080	PHYSICAL THERAPY	66.00	0	33.00
33.01	LOSS ON DISPOSAL OF ASSETS	A	3,420	CAP REL COSTS-MVBLE EQUIP	2.00	14	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/16/2016 4:48 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	LOBBYING OFFSET	A	-1,253	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	INCENTIVE COMP SALARY ACCRUAL	A	-345,374	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	INCENTIVE COMP FICA ACCRUAL	A	-26,421	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05			0		0.00	0	33.05
33.06			0		0.00	0	33.06
33.07			0		0.00	0	33.07
33.08			0		0.00	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		339,159				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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/16/2016 4:48 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH SELF INSURANCE	2,232,144	2,204,533	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,734,840	2,048,121	2.00
3.00	194.01	MARKETING	HOME OFFICE	158,754	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	527,275	527,275	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	350,308	350,308	3.02
3.03	7.00	OPERATION OF PLANT	SVH CHARGEBACK	147,942	147,942	3.03
3.04	13.00	NURSING ADMINISTRATION	SVH CHARGEBACK	22,410	22,410	3.04
3.05	15.00	PHARMACY	SVH CHARGEBACK	21,143	21,143	3.05
3.06	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACK	22,410	22,410	3.06
3.07	18.00	PASTORAL CARE	SVH CHARGEBACK	73,678	73,678	3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	109,089	109,089	3.08
3.09	54.01	ULTRA SOUND	SVH CHARGEBACK	25,046	25,046	3.09
3.10	57.00	CT SCAN	SVH CHARGEBACK	109,982	109,982	3.10
3.11	65.00	RESPIRATORY THERAPY	SVH CHARGEBACK	182	182	3.11
3.12	7.00	OPERATION OF PLANT	TRIMEDX	1,024,168	1,082,612	3.12
4.00	1.00	CAP REL COSTS-BLDG & FIXT	AH INTEREST CAPITAL	11,846	12,775	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	AH INTEREST A&G	215	231	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,571,432	6,757,737	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	ST VINCENT HEAL	100.00		0.00	6.00
7.00	G	ASCENSION	100.00		0.00	7.00
8.00	A	TRIMEDX	100.00		0.00	8.00
9.00			0.00		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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/16/2016 4:48 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	27,611	0		1.00
2.00	686,719	0		2.00
3.00	158,754	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	-58,444	0		3.12
4.00	-929	11		4.00
4.01	-16	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
5.00	813,695			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			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.

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/16/2016 4:48 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	947,049	947,049				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	621,559		621,559			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,695,281	0	0	3,695,281		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,124,321	50,145	32,911	538,501	6,745,878	5.00
7.00	00700	OPERATION OF PLANT	1,664,134	47,455	31,145	24,569	1,767,303	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	66,361	7,747	5,084	0	79,192	8.00
9.00	00900	HOUSEKEEPING	503,584	10,762	7,063	0	521,409	9.00
10.00	01000	DIETARY	652,634	38,410	25,209	0	716,253	10.00
13.00	01300	NURSING ADMINISTRATION	1,264,325	62,509	41,026	239,786	1,607,646	13.00
15.00	01500	PHARMACY	3,983,653	22,554	14,802	304,635	4,325,644	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	166,441	10,247	6,725	7,644	191,057	16.00
17.00	01700	SOCIAL SERVICE	153,807	5,629	3,694	32,510	195,640	17.00
18.00	01851	PASTORAL CARE	73,678	6,945	4,558	16,429	101,610	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,616,602	634,748	416,593	1,707,725	12,375,668	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	382,231	6,793	4,458	41,889	435,371	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	269,445	12,212	8,015	37,315	326,987	54.00
54.01	03630	ULTRA SOUND	84,135	0	0	17,113	101,248	54.01
57.00	05700	CT SCAN	167,990	3,244	2,129	34,423	207,786	57.00
60.00	06000	LABORATORY	789,682	2,652	1,741	0	794,075	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	112,114	0	0	0	112,114	63.00
65.00	06500	RESPIRATORY THERAPY	2,636,240	4,808	3,156	484,910	3,129,114	65.00
66.00	06600	PHYSICAL THERAPY	570,695	6,736	4,421	112,509	694,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	291,056	6,736	4,421	59,191	361,404	67.00
68.00	06800	SPEECH PATHOLOGY	172,876	6,717	4,408	35,985	219,986	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,526	0	0	147	3,673	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,282,288	0	0	0	1,282,288	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
74.00	07400	RENAL DIALYSIS	672,547	0	0	0	672,547	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,968,254	947,049	621,559	3,695,281	36,968,254	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	1,697	0	0	0	1,697	194.00
194.01	07951	MARKETING	158,754	0	0	0	158,754	194.01
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)	37,128,705	947,049	621,559	3,695,281	37,128,705	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/16/2016 4:48 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	6,745,878					5.00
7.00	00700	OPERATION OF PLANT	392,393	2,159,696				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,583	19,696	116,471			8.00
9.00	00900	HOUSEKEEPING	115,768	27,361	0	664,538		9.00
10.00	01000	DIETARY	159,029	97,656	0	30,718	1,003,656	10.00
13.00	01300	NURSING ADMINISTRATION	356,944	158,928	0	49,991	0	13.00
15.00	01500	PHARMACY	960,418	57,342	0	18,037	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,420	26,051	0	8,195	0	16.00
17.00	01700	SOCIAL SERVICE	43,438	14,311	0	4,502	0	17.00
18.00	01851	PASTORAL CARE	22,560	17,659	0	5,555	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,747,765	1,613,831	116,471	507,636	1,003,656	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	96,665	17,271	0	5,433	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,601	31,048	0	9,766	0	54.00
54.01	03630	ULTRA SOUND	22,480	0	0	0	0	54.01
57.00	05700	CT SCAN	46,135	8,247	0	2,594	0	57.00
60.00	06000	LABORATORY	176,308	6,743	0	2,121	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	24,893	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	694,754	12,225	0	3,845	0	65.00
66.00	06600	PHYSICAL THERAPY	154,168	17,125	0	5,387	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	80,242	17,125	0	5,387	0	67.00
68.00	06800	SPEECH PATHOLOGY	48,843	17,077	0	5,371	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	816	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	284,705	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
74.00	07400	RENAL DIALYSIS	149,325	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,710,253	2,159,696	116,471	664,538	1,003,656	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	377	0	0	0	0	194.00
194.01	07951	MARKETING	35,248	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,745,878	2,159,696	116,471	664,538	1,003,656	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/16/2016 4:48 pm

		Cost Center Description	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PASTORAL CARE	
			13.00	15.00	16.00	17.00	18.00	
		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
13.00	01300	NURSING ADMINISTRATION	2,173,509					13.00
15.00	01500	PHARMACY	0	5,361,441				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	267,723			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	257,891		17.00
18.00	01851	PASTORAL CARE	0	0	0	0	147,384	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,563,654	0	98,833	257,891	147,384	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,900	0	3,796	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,181	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	2,317	0	0	54.01
57.00	05700	CT SCAN	0	0	862	0	0	57.00
60.00	06000	LABORATORY	0	0	22,663	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	984	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	405,351	0	64,541	0	0	65.00
66.00	06600	PHYSICAL THERAPY	98,258	0	6,291	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,327	0	5,704	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	28,019	0	2,080	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	90	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	8,680	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	5,361,441	41,406	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	5,295	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,173,509	5,361,441	267,723	257,891	147,384	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	2,173,509	5,361,441	267,723	257,891	147,384	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/16/2016 4:48 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
18.00	01851	PASTORAL CARE					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	20,432,789	0	20,432,789		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	586,436	0	586,436		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,583	0	444,583		54.00
54.01	03630	ULTRA SOUND	126,045	0	126,045		54.01
57.00	05700	CT SCAN	265,624	0	265,624		57.00
60.00	06000	LABORATORY	1,001,910	0	1,001,910		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	137,991	0	137,991		63.00
65.00	06500	RESPIRATORY THERAPY	4,309,830	0	4,309,830		65.00
66.00	06600	PHYSICAL THERAPY	975,590	0	975,590		66.00
67.00	06700	OCCUPATIONAL THERAPY	520,189	0	520,189		67.00
68.00	06800	SPEECH PATHOLOGY	321,376	0	321,376		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,579	0	4,579		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,575,673	0	1,575,673		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,402,847	0	5,402,847		73.00
74.00	07400	RENAL DIALYSIS	827,167	0	827,167		74.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,932,629	0	36,932,629		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	BIOTERRORISM GRANT	2,074	0	2,074		194.00
194.01	07951	MARKETING	194,002	0	194,002		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	37,128,705	0	37,128,705		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/16/2016 4:48 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	621,557	50,145	32,911	704,613	0	5.00
7.00	00700	OPERATION OF PLANT	0	47,455	31,145	78,600	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,747	5,084	12,831	0	8.00
9.00	00900	HOUSEKEEPING	0	10,762	7,063	17,825	0	9.00
10.00	01000	DIETARY	0	38,410	25,209	63,619	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	62,509	41,026	103,535	0	13.00
15.00	01500	PHARMACY	0	22,554	14,802	37,356	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,247	6,725	16,972	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,629	3,694	9,323	0	17.00
18.00	01851	PASTORAL CARE	0	6,945	4,558	11,503	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	634,748	416,593	1,051,341	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,793	4,458	11,251	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,212	8,015	20,227	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	3,244	2,129	5,373	0	57.00
60.00	06000	LABORATORY	0	2,652	1,741	4,393	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	4,808	3,156	7,964	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,736	4,421	11,157	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,736	4,421	11,157	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,717	4,408	11,125	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	621,557	947,049	621,559	2,190,165	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	621,557	947,049	621,559	2,190,165	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/16/2016 4:48 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	704,613					5.00
7.00	00700	OPERATION OF PLANT	40,986	119,586				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,837	1,091	15,759			8.00
9.00	00900	HOUSEKEEPING	12,092	1,515	0	31,432		9.00
10.00	01000	DIETARY	16,611	5,407	0	1,453	87,090	10.00
13.00	01300	NURSING ADMINISTRATION	37,283	8,800	0	2,365	0	13.00
15.00	01500	PHARMACY	100,316	3,175	0	853	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,431	1,443	0	388	0	16.00
17.00	01700	SOCIAL SERVICE	4,537	792	0	213	0	17.00
18.00	01851	PASTORAL CARE	2,356	978	0	263	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	287,008	89,361	15,759	24,009	87,090	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,097	956	0	257	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,583	1,719	0	462	0	54.00
54.01	03630	ULTRA SOUND	2,348	0	0	0	0	54.01
57.00	05700	CT SCAN	4,819	457	0	123	0	57.00
60.00	06000	LABORATORY	18,415	373	0	100	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,600	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	72,567	677	0	182	0	65.00
66.00	06600	PHYSICAL THERAPY	16,103	948	0	255	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,381	948	0	255	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,102	946	0	254	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	85	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,738	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
74.00	07400	RENAL DIALYSIS	15,597	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	700,892	119,586	15,759	31,432	87,090	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	39	0	0	0	0	194.00
194.01	07951	MARKETING	3,682	0	0	0	0	194.01
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)	704,613	119,586	15,759	31,432	87,090	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/16/2016 4:48 pm

		Cost Center Description	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PASTORAL CARE	
			13.00	15.00	16.00	17.00	18.00	
		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
13.00	01300	NURSING ADMINISTRATION	151,983					13.00
15.00	01500	PHARMACY	0	141,700				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	23,234			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	14,865		17.00
18.00	01851	PASTORAL CARE	0	0	0	0	15,100	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,339	0	8,571	14,865	15,100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,951	0	330	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	363	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	201	0	0	54.01
57.00	05700	CT SCAN	0	0	75	0	0	57.00
60.00	06000	LABORATORY	0	0	1,967	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	85	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	28,344	0	5,603	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,871	0	546	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,519	0	495	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,959	0	181	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	8	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	754	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	141,700	3,595	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	460	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	151,983	141,700	23,234	14,865	15,100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	151,983	141,700	23,234	14,865	15,100	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/16/2016 4:48 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01851	PASTORAL CARE				18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,702,443	0	1,702,443	30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	24,842	0	24,842	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,354	0	30,354	54.00
54.01	03630	ULTRA SOUND	2,549	0	2,549	54.01
57.00	05700	CT SCAN	10,847	0	10,847	57.00
60.00	06000	LABORATORY	25,248	0	25,248	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,685	0	2,685	63.00
65.00	06500	RESPIRATORY THERAPY	115,337	0	115,337	65.00
66.00	06600	PHYSICAL THERAPY	35,880	0	35,880	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,755	0	24,755	67.00
68.00	06800	SPEECH PATHOLOGY	19,567	0	19,567	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93	0	93	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,492	0	30,492	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,295	0	145,295	73.00
74.00	07400	RENAL DIALYSIS	16,057	0	16,057	74.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,186,444	0	2,186,444	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	39	0	39	194.00
194.01	07951	MARKETING	3,682	0	3,682	194.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,190,165	0	2,190,165	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/16/2016 4:48 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	49,633					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		49,633				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	16,302,419			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,628	2,628	2,375,695	-6,745,878	30,382,827	5.00
7.00	00700	OPERATION OF PLANT	2,487	2,487	108,392	0	1,767,303	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	406	406	0	0	79,192	8.00
9.00	00900	HOUSEKEEPING	564	564	0	0	521,409	9.00
10.00	01000	DIETARY	2,013	2,013	0	0	716,253	10.00
13.00	01300	NURSING ADMINISTRATION	3,276	3,276	1,057,859	0	1,607,646	13.00
15.00	01500	PHARMACY	1,182	1,182	1,343,951	0	4,325,644	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	537	537	33,725	0	191,057	16.00
17.00	01700	SOCIAL SERVICE	295	295	143,425	0	195,640	17.00
18.00	01851	PASTORAL CARE	364	364	72,478	0	101,610	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,266	33,266	7,533,957	0	12,375,668	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	356	356	184,801	0	435,371	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	640	640	164,621	0	326,987	54.00
54.01	03630	ULTRA SOUND	0	0	75,499	0	101,248	54.01
57.00	05700	CT SCAN	170	170	151,863	0	207,786	57.00
60.00	06000	LABORATORY	139	139	0	0	794,075	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	112,114	63.00
65.00	06500	RESPIRATORY THERAPY	252	252	2,139,266	0	3,129,114	65.00
66.00	06600	PHYSICAL THERAPY	353	353	496,352	0	694,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	353	353	261,131	0	361,404	67.00
68.00	06800	SPEECH PATHOLOGY	352	352	158,754	0	219,986	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	650	0	3,673	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,282,288	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	672,547	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,633	49,633	16,302,419	-6,745,878	30,222,376	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0	1,697	194.00
194.01	07951	MARKETING	0	0	0	0	158,754	194.01
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)	947,049	621,559	3,695,281		6,745,878	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.081035	12.523100	0.226671		0.222029	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		704,613	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.023191	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/16/2016 4:48 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			7.00	8.00	9.00	10.00	13.00	
		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	44,518					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	406	100				8.00
9.00	00900	HOUSEKEEPING	564	0	43,548			9.00
10.00	01000	DIETARY	2,013	0	2,013	21,246		10.00
13.00	01300	NURSING ADMINISTRATION	3,276	0	3,276	0	367,311	13.00
15.00	01500	PHARMACY	1,182	0	1,182	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	537	0	537	0	0	16.00
17.00	01700	SOCIAL SERVICE	295	0	295	0	0	17.00
18.00	01851	PASTORAL CARE	364	0	364	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,266	100	33,266	21,246	264,249	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	356	0	356	0	4,715	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	640	0	640	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	170	0	170	0	0	57.00
60.00	06000	LABORATORY	139	0	139	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	252	0	252	0	68,502	65.00
66.00	06600	PHYSICAL THERAPY	353	0	353	0	16,605	66.00
67.00	06700	OCCUPATIONAL THERAPY	353	0	353	0	8,505	67.00
68.00	06800	SPEECH PATHOLOGY	352	0	352	0	4,735	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,518	100	43,548	21,246	367,311	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,159,696	116,471	664,538	1,003,656	2,173,509	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.512871	1,164.710000	15.259897	47.239763	5.917353	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	119,586	15,759	31,432	87,090	151,983	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.686239	157.590000	0.721778	4.099125	0.413772	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/16/2016 4:48 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE PASTORAL CARE (TOTAL PATIENT DAYS)		
			15.00	16.00	17.00	18.00		
		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
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	1,000					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	127,029,406				16.00
17.00	01700	SOCIAL SERVICE	0	0	21,246			17.00
18.00	01851	PASTORAL CARE	0	0	0	21,246		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	46,910,625	21,246	21,246		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,800,848	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,983,287	0	0		54.00
54.01	03630	ULTRA SOUND	0	1,099,209	0	0		54.01
57.00	05700	CT SCAN	0	408,946	0	0		57.00
60.00	06000	LABORATORY	0	10,751,041	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	466,623	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	30,617,228	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,984,341	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,705,826	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	986,617	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	42,737	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,117,695	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,000	19,642,489	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	2,511,894	0	0		74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,000	127,029,406	21,246	21,246		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	BIOTERRORISM GRANT	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
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)	5,361,441	267,723	257,891	147,384		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5,361.441000	0.002108	12.138332	6.937023		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	141,700	23,234	14,865	15,100		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	141.700000	0.000183	0.699661	0.710722		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

		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	20,432,789		20,432,789	0	20,432,789	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	586,436		586,436	0	586,436	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,583		444,583	0	444,583	54.00
54.01	03630	ULTRA SOUND	126,045		126,045	0	126,045	54.01
57.00	05700	CT SCAN	265,624		265,624	0	265,624	57.00
60.00	06000	LABORATORY	1,001,910		1,001,910	0	1,001,910	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	137,991		137,991	0	137,991	63.00
65.00	06500	RESPIRATORY THERAPY	4,309,830	0	4,309,830	0	4,309,830	65.00
66.00	06600	PHYSICAL THERAPY	975,590	0	975,590	0	975,590	66.00
67.00	06700	OCCUPATIONAL THERAPY	520,189	0	520,189	0	520,189	67.00
68.00	06800	SPEECH PATHOLOGY	321,376	0	321,376	0	321,376	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,579		4,579	0	4,579	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,575,673		1,575,673	0	1,575,673	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,402,847		5,402,847	0	5,402,847	73.00
74.00	07400	RENAL DIALYSIS	827,167		827,167	0	827,167	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,932,629	0	36,932,629	0	36,932,629	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	36,932,629	0	36,932,629	0	36,932,629	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

		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	46,910,625		46,910,625			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,800,848	0	1,800,848	0.325644	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,974,414	8,873	1,983,287	0.224165	0.000000	54.00
54.01	03630	ULTRA SOUND	1,099,209	0	1,099,209	0.114669	0.000000	54.01
57.00	05700	CT SCAN	404,696	4,250	408,946	0.649533	0.000000	57.00
60.00	06000	LABORATORY	10,682,788	68,253	10,751,041	0.093192	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	466,623	0	466,623	0.295723	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	30,617,039	189	30,617,228	0.140765	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,981,702	2,639	2,984,341	0.326903	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,703,854	1,972	2,705,826	0.192248	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	985,716	901	986,617	0.325735	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,057	1,680	42,737	0.107144	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,090,728	26,967	4,117,695	0.382659	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,642,466	23	19,642,489	0.275059	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,511,894	0	2,511,894	0.329300	0.000000	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	126,913,659	115,747	127,029,406			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	126,913,659	115,747	127,029,406			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/16/2016 4:48 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.325644	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224165	54.00
54.01	03630	ULTRA SOUND	0.114669	54.01
57.00	05700	CT SCAN	0.649533	57.00
60.00	06000	LABORATORY	0.093192	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.295723	63.00
65.00	06500	RESPIRATORY THERAPY	0.140765	65.00
66.00	06600	PHYSICAL THERAPY	0.326903	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.192248	67.00
68.00	06800	SPEECH PATHOLOGY	0.325735	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.107144	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.275059	73.00
74.00	07400	RENAL DIALYSIS	0.329300	74.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/16/2016 4:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	20,432,789		20,432,789	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	586,436		586,436	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,583		444,583	0	0	54.00
54.01	03630	ULTRA SOUND	126,045		126,045	0	0	54.01
57.00	05700	CT SCAN	265,624		265,624	0	0	57.00
60.00	06000	LABORATORY	1,001,910		1,001,910	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	137,991		137,991	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,309,830	0	4,309,830	0	0	65.00
66.00	06600	PHYSICAL THERAPY	975,590	0	975,590	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	520,189	0	520,189	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	321,376	0	321,376	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,579		4,579	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,575,673		1,575,673	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,402,847		5,402,847	0	0	73.00
74.00	07400	RENAL DIALYSIS	827,167		827,167	0	0	74.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,932,629	0	36,932,629	0	0	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	36,932,629	0	36,932,629	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/16/2016 4:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,910,625		46,910,625			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,800,848	0	1,800,848	0.325644	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,974,414	8,873	1,983,287	0.224165	0.000000	54.00
54.01	03630	ULTRA SOUND	1,099,209	0	1,099,209	0.114669	0.000000	54.01
57.00	05700	CT SCAN	404,696	4,250	408,946	0.649533	0.000000	57.00
60.00	06000	LABORATORY	10,682,788	68,253	10,751,041	0.093192	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	466,623	0	466,623	0.295723	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	30,617,039	189	30,617,228	0.140765	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,981,702	2,639	2,984,341	0.326903	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,703,854	1,972	2,705,826	0.192248	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	985,716	901	986,617	0.325735	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,057	1,680	42,737	0.107144	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,090,728	26,967	4,117,695	0.382659	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,642,466	23	19,642,489	0.275059	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,511,894	0	2,511,894	0.329300	0.000000	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	126,913,659	115,747	127,029,406			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	126,913,659	115,747	127,029,406			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/16/2016 4:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
57.00	05700	CT SCAN	0.000000	57.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II | Date/Time Prepared: 11/16/2016 4:48 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	586,436	24,842	561,594	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,583	30,354	414,229	0	0	54.00
54.01	03630	ULTRA SOUND	126,045	2,549	123,496	0	0	54.01
57.00	05700	CT SCAN	265,624	10,847	254,777	0	0	57.00
60.00	06000	LABORATORY	1,001,910	25,248	976,662	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	137,991	2,685	135,306	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,309,830	115,337	4,194,493	0	0	65.00
66.00	06600	PHYSICAL THERAPY	975,590	35,880	939,710	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	520,189	24,755	495,434	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	321,376	19,567	301,809	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,579	93	4,486	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,575,673	30,492	1,545,181	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	5,402,847	145,295	5,257,552	0	0	73.00
74.00	07400	RENAL DIALYSIS	827,167	16,057	811,110	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	16,499,840	484,001	16,015,839	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	16,499,840	484,001	16,015,839	0	0	202.00

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

Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II | Date/Time Prepared: 11/16/2016 4:48 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	586,436	1,800,848	0.325644	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,583	1,983,287	0.224165	54.00
54.01	03630	ULTRA SOUND	126,045	1,099,209	0.114669	54.01
57.00	05700	CT SCAN	265,624	408,946	0.649533	57.00
60.00	06000	LABORATORY	1,001,910	10,751,041	0.093192	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	137,991	466,623	0.295723	63.00
65.00	06500	RESPIRATORY THERAPY	4,309,830	30,617,228	0.140765	65.00
66.00	06600	PHYSICAL THERAPY	975,590	2,984,341	0.326903	66.00
67.00	06700	OCCUPATIONAL THERAPY	520,189	2,705,826	0.192248	67.00
68.00	06800	SPEECH PATHOLOGY	321,376	986,617	0.325735	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,579	42,737	0.107144	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,575,673	4,117,695	0.382659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,402,847	19,642,489	0.275059	73.00
74.00	07400	RENAL DIALYSIS	827,167	2,511,894	0.329300	74.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	16,499,840	80,118,781		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	16,499,840	80,118,781		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

	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	1,702,443	0	1,702,443	21,246	80.13	30.00
200.00	Total (lines 30-199)	1,702,443		1,702,443	21,246		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	10,912	874,379	30.00
200.00	Total (lines 30-199)	10,912	874,379	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

		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	24,842	1,800,848	0.013795	1,632,425	22,519	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,354	1,983,287	0.015305	1,139,540	17,441	54.00
54.01	03630	ULTRA SOUND	2,549	1,099,209	0.002319	0	0	54.01
57.00	05700	CT SCAN	10,847	408,946	0.026524	181,900	4,825	57.00
60.00	06000	LABORATORY	25,248	10,751,041	0.002348	5,756,614	13,517	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,685	466,623	0.005754	400,102	2,302	63.00
65.00	06500	RESPIRATORY THERAPY	115,337	30,617,228	0.003767	13,980,057	52,663	65.00
66.00	06600	PHYSICAL THERAPY	35,880	2,984,341	0.012023	1,470,604	17,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,755	2,705,826	0.009149	1,338,976	12,250	67.00
68.00	06800	SPEECH PATHOLOGY	19,567	986,617	0.019832	483,657	9,592	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93	42,737	0.002176	25,789	56	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,492	4,117,695	0.007405	1,874,419	13,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,295	19,642,489	0.007397	9,651,210	71,390	73.00
74.00	07400	RENAL DIALYSIS	16,057	2,511,894	0.006392	1,464,979	9,364	74.00
200.00		Total (lines 50-199)	484,001	80,118,781		39,400,272	247,480	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,246	0.00	10,912	0	30.00
200.00		Total (lines 30-199)	21,246		10,912	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/16/2016 4:48 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

		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	1,800,848	0.000000	0.000000	1,632,425	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,983,287	0.000000	0.000000	1,139,540	54.00
54.01	03630	ULTRA SOUND	0	1,099,209	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	408,946	0.000000	0.000000	181,900	57.00
60.00	06000	LABORATORY	0	10,751,041	0.000000	0.000000	5,756,614	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	466,623	0.000000	0.000000	400,102	63.00
65.00	06500	RESPIRATORY THERAPY	0	30,617,228	0.000000	0.000000	13,980,057	65.00
66.00	06600	PHYSICAL THERAPY	0	2,984,341	0.000000	0.000000	1,470,604	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,705,826	0.000000	0.000000	1,338,976	67.00
68.00	06800	SPEECH PATHOLOGY	0	986,617	0.000000	0.000000	483,657	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	42,737	0.000000	0.000000	25,789	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,117,695	0.000000	0.000000	1,874,419	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,642,489	0.000000	0.000000	9,651,210	73.00
74.00	07400	RENAL DIALYSIS	0	2,511,894	0.000000	0.000000	1,464,979	74.00
200.00		Total (lines 50-199)	0	80,118,781			39,400,272	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

		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	0.325644	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224165	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.114669	0	0	0	0	54.01
57.00	05700	CT SCAN	0.649533	0	0	0	0	57.00
60.00	06000	LABORATORY	0.093192	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.295723	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.140765	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.326903	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.192248	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.325735	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.107144	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382659	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.275059	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.329300	0	0	0	0	74.00
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: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/16/2016 4:48 pm
	Title XVIII	Hospital	PPS

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
57.00	05700	CT SCAN	0	0	57.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/16/2016 4:48 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	1,702,443	0	1,702,443	21,246	80.13	30.00
200.00	Total (lines 30-199)	1,702,443		1,702,443	21,246		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	1,403	112,422	30.00
200.00	Total (lines 30-199)	1,403	112,422	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/16/2016 4:48 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	24,842	1,800,848	0.013795	165,723	2,286	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,354	1,983,287	0.015305	130,698	2,000	54.00
54.01	03630	ULTRA SOUND	2,549	1,099,209	0.002319	48,532	113	54.01
57.00	05700	CT SCAN	10,847	408,946	0.026524	32,617	865	57.00
60.00	06000	LABORATORY	25,248	10,751,041	0.002348	755,059	1,773	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,685	466,623	0.005754	30,759	177	63.00
65.00	06500	RESPIRATORY THERAPY	115,337	30,617,228	0.003767	2,078,683	7,830	65.00
66.00	06600	PHYSICAL THERAPY	35,880	2,984,341	0.012023	221,061	2,658	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,755	2,705,826	0.009149	193,009	1,766	67.00
68.00	06800	SPEECH PATHOLOGY	19,567	986,617	0.019832	68,660	1,362	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93	42,737	0.002176	3,513	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,492	4,117,695	0.007405	79,631	590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,295	19,642,489	0.007397	1,528,199	11,304	73.00
74.00	07400	RENAL DIALYSIS	16,057	2,511,894	0.006392	78,999	505	74.00
200.00		Total (lines 50-199)	484,001	80,118,781		5,415,143	33,237	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/16/2016 4:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0		0	200.00
		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,246	0.00	1,403	0		30.00
200.00		Total (lines 30-199)	21,246		1,403	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/16/2016 4:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/16/2016 4:48 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	1,800,848	0.000000	0.000000	165,723	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,983,287	0.000000	0.000000	130,698	54.00
54.01	03630	ULTRA SOUND	0	1,099,209	0.000000	0.000000	48,532	54.01
57.00	05700	CT SCAN	0	408,946	0.000000	0.000000	32,617	57.00
60.00	06000	LABORATORY	0	10,751,041	0.000000	0.000000	755,059	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	466,623	0.000000	0.000000	30,759	63.00
65.00	06500	RESPIRATORY THERAPY	0	30,617,228	0.000000	0.000000	2,078,683	65.00
66.00	06600	PHYSICAL THERAPY	0	2,984,341	0.000000	0.000000	221,061	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,705,826	0.000000	0.000000	193,009	67.00
68.00	06800	SPEECH PATHOLOGY	0	986,617	0.000000	0.000000	68,660	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	42,737	0.000000	0.000000	3,513	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,117,695	0.000000	0.000000	79,631	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,642,489	0.000000	0.000000	1,528,199	73.00
74.00	07400	RENAL DIALYSIS	0	2,511,894	0.000000	0.000000	78,999	74.00
200.00		Total (lines 50-199)	0	80,118,781			5,415,143	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/16/2016 4:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
200.00		Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

	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)	21,246	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,246	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)	21,246	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	10,912	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	20,432,789	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)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	20,432,789	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)	20,432,789	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)	961.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	10,494,289	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)	10,494,289	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,280,676	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	18,774,965	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)	874,379	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	247,480	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,121,859	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	17,653,106	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

	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	1,702,443	20,432,789	0.083319	0	0	90.00
91.00	Nursing School cost	0	20,432,789	0.000000	0	0	91.00
92.00	Allied health cost	0	20,432,789	0.000000	0	0	92.00
93.00	All other Medical Education	0	20,432,789	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/16/2016 4:48 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)	21,246	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,246	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)	21,246	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,403	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	20,432,789	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)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	20,432,789	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)	20,432,789	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)	961.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,349,293	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)	1,349,293	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/16/2016 4:48 pm
	Title XIX	Hospital	Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,091,027	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,440,320	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/16/2016 4:48 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	1,702,443	20,432,789	0.083319	0	0	90.00
91.00	Nursing School cost	0	20,432,789	0.000000	0	0	91.00
92.00	Allied health cost	0	20,432,789	0.000000	0	0	92.00
93.00	All other Medical Education	0	20,432,789	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/16/2016 4:48 pm
	Title XVIII	Hospital	PPS

		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		24,041,804		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.325644	1,632,425	531,589	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224165	1,139,540	255,445	54.00
54.01	03630	ULTRA SOUND	0.114669	0	0	54.01
57.00	05700	CT SCAN	0.649533	181,900	118,150	57.00
60.00	06000	LABORATORY	0.093192	5,756,614	536,470	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.295723	400,102	118,319	63.00
65.00	06500	RESPIRATORY THERAPY	0.140765	13,980,057	1,967,903	65.00
66.00	06600	PHYSICAL THERAPY	0.326903	1,470,604	480,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.192248	1,338,976	257,415	67.00
68.00	06800	SPEECH PATHOLOGY	0.325735	483,657	157,544	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.107144	25,789	2,763	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382659	1,874,419	717,263	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.275059	9,651,210	2,654,652	73.00
74.00	07400	RENAL DIALYSIS	0.329300	1,464,979	482,418	74.00
200.00		Total (sum of lines 50-94 and 96-98)		39,400,272	8,280,676	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)		39,400,272		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/16/2016 4:48 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		3,645,671		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.325644	165,723	53,967	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224165	130,698	29,298	54.00
54.01	03630	ULTRA SOUND	0.114669	48,532	5,565	54.01
57.00	05700	CT SCAN	0.649533	32,617	21,186	57.00
60.00	06000	LABORATORY	0.093192	755,059	70,365	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.295723	30,759	9,096	63.00
65.00	06500	RESPIRATORY THERAPY	0.140765	2,078,683	292,606	65.00
66.00	06600	PHYSICAL THERAPY	0.326903	221,061	72,266	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.192248	193,009	37,106	67.00
68.00	06800	SPEECH PATHOLOGY	0.325735	68,660	22,365	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.107144	3,513	376	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382659	79,631	30,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.275059	1,528,199	420,345	73.00
74.00	07400	RENAL DIALYSIS	0.329300	78,999	26,014	74.00
200.00		Total (sum of lines 50-94 and 96-98)		5,415,143	1,091,027	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)		5,415,143		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part B Date/Time Prepared: 11/16/2016 4:48 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	5,272	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)	0	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)	0	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)	5,272	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,298	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)	3,974	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)	3,974	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,974	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,974	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,974	40.00
40.01	Sequestration adjustment (see instructions)	79	40.01
41.00	Interim payments	3,895	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	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: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part I Date/Time Prepared: 11/16/2016 4:48 pm
	Title XVIII	Hospital	PPS

		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		17,357,386		3,895	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	01/26/2016	96,000		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)		96,000		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)		17,453,386		3,895	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		186,087		0	6.02
7.00	Total Medicare program liability (see instructions)		17,267,299		3,895	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	Provider CCN: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part IV Date/Time Prepared: 11/16/2016 4:48 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	15,679,323	1.00
2.00	Outlier Payments	3,259,011	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	18,938,334	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	18,938,334	7.00
8.00	Primary payer payments	2,447	8.00
9.00	Subtotal (line 7 less line 8).	18,935,887	9.00
10.00	Deductibles	31,808	10.00
11.00	Subtotal (line 9 minus line 10)	18,904,079	11.00
12.00	Coinsurance	1,685,306	12.00
13.00	Subtotal (line 11 minus line 12)	17,218,773	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	616,800	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	400,920	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	589,391	16.00
17.00	Subtotal (sum of lines 13 and 15)	17,619,693	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.99	Recovery of Accelerated Depreciation	0	21.99
22.00	Total amount payable to the provider (see instructions)	17,619,693	22.00
22.01	Sequestration adjustment (see instructions)	352,394	22.01
23.00	Interim payments	17,453,386	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)	-186,087	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-3 Part VII Date/Time Prepared: 11/16/2016 4:48 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	2,440,320		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)	2,440,320	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)	2,440,320	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	2,161,762		8.00
9.00	Ancillary service charges	5,415,143	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)	7,576,905	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)	7,576,905	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,136,585	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)	2,440,320	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)	2,440,320	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)	2,440,320	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)	2,440,320	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,440,320	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)	2,440,320	0	40.00
41.00	Interim payments	2,440,320	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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/16/2016 4:48 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	0	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	18,945,817	0	0	0	4.00
5.00	Other receivable	379,265	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,791,874	0	0	0	6.00
7.00	Inventory	348,602	0	0	0	7.00
8.00	Prepaid expenses	14,843	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,896,653	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	847,629	0	0	0	12.00
13.00	Land improvements	3,157	0	0	0	13.00
14.00	Accumulated depreciation	-2,552	0	0	0	14.00
15.00	Buildings	17,095,253	0	0	0	15.00
16.00	Accumulated depreciation	-7,906,788	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	4,959,032	0	0	0	23.00
24.00	Accumulated depreciation	-3,526,864	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)	11,468,867	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	84,199,029	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	13,011	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	84,212,040	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	106,577,560	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	887,475	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,253,893	0	0	0	38.00
39.00	Payroll taxes payable	136,024	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	1,385,777	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,663,169	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	409,403	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	409,403	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,072,572	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	101,504,988				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	101,504,988	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	106,577,560	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES	Provider CCN: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet G-1 Date/Time Prepared: 11/16/2016 4:48 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		95,171,128		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,333,860				2.00
3.00	Total (sum of line 1 and line 2)		101,504,988		0		3.00
4.00		0		0		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		0		10.00
11.00	Subtotal (line 3 plus line 10)		101,504,988		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		101,504,988		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00			0		4.00
5.00			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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			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: 152020 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/16/2016 4:48 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	45,891,577		45,891,577	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)	45,891,577		45,891,577	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)	45,891,577		45,891,577	17.00
18.00	Ancillary services	78,233,161	115,747	78,348,908	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	124,124,738	115,747	124,240,485	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,789,546		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		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)		36,789,546		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 152020	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/16/2016 4:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	124,240,485	1.00
2.00	Less contractual allowances and discounts on patients' accounts	77,787,355	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,453,130	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,789,546	4.00
5.00	Net income from service to patients (line 3 minus line 4)	9,663,584	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	98,268	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISCELLANEOUS REVENUE	6,434	24.00
24.01		0	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	104,702	25.00
26.00	Total (line 5 plus line 25)	9,768,286	26.00
27.00	LOSS ON INVESTMENTS	2,484,419	27.00
27.01	IMPAIRMENT, RESTRUCTURING, NON-RECUR	205,954	27.01
27.02	BAD DEBT EXPENSE	744,053	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	3,434,426	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,333,860	29.00