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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1335	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/28/2017 12:44 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2017 Time: 12:44 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 DUNN (15-1335) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	217,185	291,870	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	119,767	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	336,952	291,870	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 4:56 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1616 TWENTY-THIRD STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421	County: LAWRENCE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST VINCENT DUNN	151335	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT DUNN	15Z335	99915		03/03/2012	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 4:56 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2017 4:56 pm

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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 4:56 pm

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	70,068	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 4:56 pm

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

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1335	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 4:56 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/27/2017 4:56 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 4:56 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1335	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 4:56 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/27/2017 4:56 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	33,984.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	33,984.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	33,984.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2017 4:56 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)	984	33	1,416			1.00
2.00	HMO and other (see instructions)	167	96				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	216	0	243			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	43			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,200	33	1,702			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		25	642			13.00
14.00	Total (see instructions)	1,200	58	2,344	0.00	121.40	14.00
15.00	CAH visits	9,827	607	29,677			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	121.40	27.00
28.00	Observation Bed Days		0	319			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	3	92			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/27/2017 4:56 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	249	11	409	1.00
2.00	HMO and other (see instructions)			46	32		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	249	11	409	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/27/2017 4:56 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.366886	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,938,377	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,934,220	6.00
7.00	Medicaid cost (line 1 times line 6)	5,846,042	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,061,652	524,776	2,586,428	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	756,391	524,776	1,281,167	21.00
22.00	Payments received from patients for amounts previously written off as charity care	114,771	30,720	145,491	22.00
23.00	Cost of charity care (line 21 minus line 22)	641,620	494,056	1,135,676	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	611,374	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	341,459	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	525,320	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	86,054	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	215,433	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,351,109	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,351,109	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/27/2017 4:56 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		1,204,114	1,204,114	-3,588	1,200,526	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		365,662	365,662	0	365,662	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	187,009	2,534,717	2,721,726	0	2,721,726	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,385,937	2,702,280	4,088,217	-208,780	3,879,437	5.00
7.00	00700	OPERATION OF PLANT	0	2,068,799	2,068,799	0	2,068,799	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,048	79,048	0	79,048	8.00
9.00	00900	HOUSEKEEPING	0	423,270	423,270	0	423,270	9.00
10.00	01000	DIETARY	0	641,478	641,478	-480,038	161,440	10.00
11.00	01100	CAFETERIA	0	0	0	480,038	480,038	11.00
13.00	01300	NURSING ADMINISTRATION	221,591	28,724	250,315	0	250,315	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68,892	16,049	84,941	0	84,941	14.00
15.00	01500	PHARMACY	203,392	484,753	688,145	-16	688,129	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	369,033	128,054	497,087	0	497,087	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,920,440	236,251	2,156,691	-880,463	1,276,228	30.00
43.00	04300	NURSERY	0	0	0	240,469	240,469	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	616,493	473,900	1,090,393	-132,539	957,854	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	635,076	635,076	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	675,486	292,912	968,398	-289	968,109	54.00
60.00	06000	LABORATORY	0	1,555,510	1,555,510	0	1,555,510	60.00
65.00	06500	RESPIRATORY THERAPY	342,793	5,589	348,382	0	348,382	65.00
66.00	06600	PHYSICAL THERAPY	151,954	48,058	200,012	-11,352	188,660	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,658	3,223	10,881	7,304	18,185	67.00
68.00	06800	SPEECH PATHOLOGY	5,977	0	5,977	4,048	10,025	68.00
69.00	06900	ELECTROCARDIOLOGY	222,613	1,882	224,495	0	224,495	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	33,523	33,523	138,541	172,064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	182,377	182,377	0	182,377	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	48,375	1,487	49,862	0	49,862	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	419,571	419,571	0	419,571	76.00
76.97	07697	CARDIAC REHABILITATION	18,238	4,021	22,259	0	22,259	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	801,663	1,001,695	1,803,358	-779	1,802,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,247,544	14,936,947	22,184,491	-212,368	21,972,123	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	212,368	212,368	194.00
194.01	07951	FOUNDATION	37,846	428	38,274	0	38,274	194.01
194.02	07952	COMMUNITY OUTREACH	0	136	136	0	136	194.02
194.03	07953	WIC	0	135	135	0	135	194.03
194.04	07954	GRANTS	0	10,123	10,123	0	10,123	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	7,334	7,334	0	7,334	194.06
200.00		TOTAL (SUM OF LINES 118-199)	7,285,390	14,955,103	22,240,493	0	22,240,493	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/27/2017 4:56 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	-868,527	331,999		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	365,662		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	74,072	2,795,798		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	353,149	4,232,586		5.00
7.00	00700	OPERATION OF PLANT	-5,399	2,063,400		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,048		8.00
9.00	00900	HOUSEKEEPING	0	423,270		9.00
10.00	01000	DIETARY	0	161,440		10.00
11.00	01100	CAFETERIA	-76,505	403,533		11.00
13.00	01300	NURSING ADMINISTRATION	-50	250,265		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-45	84,896		14.00
15.00	01500	PHARMACY	0	688,129		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,246	490,841		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-72	1,276,156		30.00
43.00	04300	NURSERY	0	240,469		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-9,168	948,686		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	635,076		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	968,109		54.00
60.00	06000	LABORATORY	0	1,555,510		60.00
65.00	06500	RESPIRATORY THERAPY	0	348,382		65.00
66.00	06600	PHYSICAL THERAPY	0	188,660		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,185		67.00
68.00	06800	SPEECH PATHOLOGY	0	10,025		68.00
69.00	06900	ELECTROCARDIOLOGY	-30,395	194,100		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	172,064		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	182,377		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	49,862		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	419,571		76.00
76.97	07697	CARDIAC REHABILITATION	0	22,259		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-25	1,802,554		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-569,211	21,402,912		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	MARKETING	113,036	325,404		194.00
194.01	07951	FOUNDATION	0	38,274		194.01
194.02	07952	COMMUNITY OUTREACH	0	136		194.02
194.03	07953	WIC	0	135		194.03
194.04	07954	GRANTS	0	10,123		194.04
194.05	07955	VACANT SPACE	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	0	7,334		194.06
200.00		TOTAL (SUM OF LINES 118-199)	-456,175	21,784,318		200.00

RECLASSIFICATIONS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/27/2017 4:56 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	480,038		1.00
	TOTALS		0	480,038		
	B - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,588		1.00
	TOTALS		0	3,588		
	C - NURSERY AND L&D					
1.00	NURSERY	43.00	197,108	43,977		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	520,560	116,142		2.00
	TOTALS		717,668	160,119		
	D - MARKETING DEPT					
1.00	MARKETING	194.00	0	212,368		1.00
	TOTALS		0	212,368		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	138,541		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	138,541		
	F - THERAPY EXPENSES					
1.00	OCCUPATIONAL THERAPY	67.00	7,304	0		1.00
2.00	SPEECH PATHOLOGY	68.00	4,048	0		2.00
	TOTALS		11,352	0		
500.00	Grand Total: Increases		729,020	994,654		500.00

RECLASSIFICATIONS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/27/2017 4:56 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	480,038	0		1.00
	TOTALS		0	480,038			
	B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,588	9		1.00
	TOTALS		0	3,588			
	C - NURSERY AND L&D						
1.00	ADULTS & PEDIATRICS	30.00	717,668	160,119	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		717,668	160,119			
	D - MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	212,368	0		1.00
	TOTALS		0	212,368			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	2,676	0		1.00
2.00	NURSERY	43.00	0	616	0		2.00
3.00	OPERATING ROOM	50.00	0	132,539	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,626	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	289	0		5.00
6.00	PHARMACY	15.00	0	16	0		6.00
7.00	EMERGENCY	91.00	0	779	0		7.00
	TOTALS		0	138,541			
	F - THERAPY EXPENSES						
1.00	PHYSICAL THERAPY	66.00	11,352	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		11,352	0			
500.00	Grand Total: Decreases		729,020	994,654			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I Date/Time Prepared: 11/27/2017 4:56 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	100,000	0	0	0	0	1.00
2.00	Land Improvements	83,405	0	0	0	0	2.00
3.00	Buildings and Fixtures	6,114,482	0	0	0	568,426	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,184,427	503,513	0	503,513	0	5.00
6.00	Movable Equipment	3,465,857	126,227	0	126,227	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,948,171	629,740	0	629,740	568,426	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	11,948,171	629,740	0	629,740	568,426	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	100,000	0	1.00
2.00	Land Improvements	83,405	0	2.00
3.00	Buildings and Fixtures	5,546,056	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,687,940	0	5.00
6.00	Movable Equipment	3,592,084	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,009,485	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	12,009,485	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/27/2017 4:56 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	921,124	0	259,973	22,227	790	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	365,315	0	0	347	0	2.00
3.00	Total (sum of lines 1-2)	1,286,439	0	259,973	22,574	790	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	1,204,114		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	365,662		2.00
3.00	Total (sum of lines 1-2)	0	1,569,776		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/27/2017 4:56 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	5,729,461	0	5,729,461	0.477078	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,280,024	0	6,280,024	0.522922	0	2.00
3.00	Total (sum of lines 1-2)	12,009,485	0	12,009,485	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	49,009	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	365,315	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	414,324	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	259,973	22,227	790	0	331,999	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	347	0	0	365,662	2.00
3.00	Total (sum of lines 1-2)	259,973	22,574	790	0	697,661	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/27/2017 4:56 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-255,019	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-3,569	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-72,963			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,263,284			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-76,505	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,246	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING OFFSET	A	-854	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	LOSS ON SALE DISPOSAL PPE	A	-2,591	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/27/2017 4:56 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	HOSPITAL PROVIDER TAX	A	-700,043	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ENTERTAINMENT	A	-19	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	ENTERTAINMENT	A	-615	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CHARITABLE EXPENSE	A	-590	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ENTERTAINMENT	A	-50	NURSING ADMINISTRATION	13.00	0	33.06
33.07	ENTERTAINMENT	A	-72	ADULTS & PEDIATRICS	30.00	0	33.07
33.08	ENTERTAINMENT	A	-25	EMERGENCY	91.00	0	33.08
33.09	PROMOTIONAL ITEMS	A	-4,404	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	PROMOTIONAL ITEMS	A	-533	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	LATE PENALTY FEES	A	-45	CENTRAL SERVICES & SUPPLY	14.00	0	33.11
33.12	MARKETING	A	-1,021	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ADVERTISING	A	-2,400	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	MISSION POINT SHARED SAVINGS	A	-14,495	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	ADMINISTRATIVE & GENERAL	B	-150	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16			0		0.00	0	33.16
33.17	ACCRUED INVENTIVES	A	34,892	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	IMPAIRMENT WRITEDOWNS	B	-612,142	CAP REL COSTS-BLDG & FIXT	1.00	9	33.18
33.19			0		0.00	0	33.19
33.20			0		0.00	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-456,175				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/27/2017 4:56 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	0	68,107	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,988,795	889,861	2.00
3.00	194.00	MARKETING	HOME OFFICE	113,036	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST VINCENT HLTH CHARGEBACK	291,681	291,681	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ST VINCENT HLTH CHARGEBACK	1,274,880	1,274,880	4.01
4.02	13.00	NURSING ADMINISTRATION	ST VINCENT HLTH CHARGEBACK	1,162	1,162	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	ST VINCENT HLTH CHARGEBACK	75,803	75,803	4.03
4.04	15.00	PHARMACY	ST VINCENT HLTH CHARGEBACK	15,984	15,984	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	ST VINCENT HLTH CHARGEBACK	449,437	449,437	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	ST VINCENT HLTH CHARGEBACK	22,237	22,237	4.06
4.07	75.01	SLEEP DISORDER	ST VINCENT HLTH CHARGEBACK	4,400	4,400	4.07
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	1,379,827	1,291,662	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	255,019	256,385	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	3,569	3,588	4.10
4.11	7.00	OPERATION OF PLANT	MEDXCEL	741,213	746,612	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	253,009	214,969	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
4.22	0.00			0	0	4.22
4.23	0.00			0	0	4.23
4.24	0.00			0	0	4.24
4.25	0.00			0	0	4.25
4.26	0.00			0	0	4.26
5.00	0		0	6,870,052	5,606,768	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/27/2017 4:56 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	-68,107	0		1.00
2.00	1,098,934	0		2.00
3.00	113,036	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	88,165	0		4.08
4.09	-1,366	9		4.09
4.10	-19	9		4.10
4.11	-5,399	0		4.11
4.12	38,040	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
5.00	1,263,284			5.00

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

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

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

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

6.00	ADMINISTRATION		6.00
7.00	ADMINISTRATION		7.00
8.00	HOSPITAL		8.00
9.00	MEDXCEL		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/27/2017 4:56 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	33,400	33,400	0	0	0	1.00
2.00	50.00	OPERATING ROOM	9,168	9,168	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	30,395	30,395	0	0	0	3.00
4.00	91.00	EMERGENCY	914,712	0	914,712	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			987,675	72,963	914,712		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	33,400		1.00
2.00	50.00	OPERATING ROOM	0	0	0	9,168		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	30,395		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	72,963		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2017 4:56 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					18	1.00
2.00	Line 1 multiplied by 15 hours per week					270	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					86	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	727.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.26	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.63	40.63	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					59,076	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					59,076	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					59,076	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					59,076	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					3,494	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,494	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					823	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					4,317	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					4,317	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1335	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 4:56 pm

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

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

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	59,076	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	4,317	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	63,393	63.00
64.00	Total cost of outside supplier services (from your records)	46,072	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	3,494	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	823	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	4,317	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	823	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	823	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/27/2017 4:56 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	331,999	331,999				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	365,662		365,662			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,795,798	1,408	1,550	2,798,756		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,232,586	30,806	33,930	546,448	4,843,770	5.00
7.00	00700	OPERATION OF PLANT	2,063,400	43,358	47,755	0	2,154,513	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,048	4,575	5,039	0	88,662	8.00
9.00	00900	HOUSEKEEPING	423,270	4,645	5,116	0	433,031	9.00
10.00	01000	DIETARY	161,440	15,331	16,885	0	193,656	10.00
11.00	01100	CAFETERIA	403,533	0	0	0	403,533	11.00
13.00	01300	NURSING ADMINISTRATION	250,265	5,191	5,718	87,369	348,543	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	84,896	10,595	11,669	27,163	134,323	14.00
15.00	01500	PHARMACY	688,129	5,893	6,491	80,194	780,707	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	490,841	16,486	18,158	145,503	670,988	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,276,156	28,291	31,160	474,230	1,809,837	30.00
43.00	04300	NURSERY	240,469	1,684	1,854	77,716	321,723	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	948,686	34,987	38,534	243,071	1,265,278	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	635,076	21,491	23,670	205,247	885,484	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	968,109	24,909	27,435	266,331	1,286,784	54.00
60.00	06000	LABORATORY	1,555,510	8,812	9,706	0	1,574,028	60.00
65.00	06500	RESPIRATORY THERAPY	348,382	5,939	6,541	135,157	496,019	65.00
66.00	06600	PHYSICAL THERAPY	188,660	9,586	10,558	55,437	264,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,185	618	680	5,899	25,382	67.00
68.00	06800	SPEECH PATHOLOGY	10,025	490	540	3,953	15,008	68.00
69.00	06900	ELECTROCARDIOLOGY	194,100	5,985	6,591	87,772	294,448	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	172,064	0	0	0	172,064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	182,377	0	0	0	182,377	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	49,862	3,934	4,333	19,073	77,202	75.01
76.00	03950	SENIOR RENEWAL CENTER	419,571	7,167	7,894	0	434,632	76.00
76.97	07697	CARDIAC REHABILITATION	22,259	715	787	7,191	30,952	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,802,554	15,980	17,600	316,080	2,152,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,402,912	308,876	340,194	2,783,834	21,339,399	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,142	1,258	0	2,400	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,570	23,757	0	45,327	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	325,404	0	0	0	325,404	194.00
194.01	07951	FOUNDATION	38,274	411	453	14,922	54,060	194.01
194.02	07952	COMMUNITY OUTREACH	136	0	0	0	136	194.02
194.03	07953	WIC	135	0	0	0	135	194.03
194.04	07954	GRANTS	10,123	0	0	0	10,123	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	7,334	0	0	0	7,334	194.06
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,784,318	331,999	365,662	2,798,756	21,784,318	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/27/2017 4:56 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,843,770					5.00
7.00	00700	OPERATION OF PLANT	616,029	2,770,542				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,351	45,777	159,790			8.00
9.00	00900	HOUSEKEEPING	123,816	46,472	0	603,319		9.00
10.00	01000	DIETARY	55,372	153,388	0	34,552	436,968	10.00
11.00	01100	CAFETERIA	115,381	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	99,658	51,940	0	11,700	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	38,407	106,002	0	23,878	0	14.00
15.00	01500	PHARMACY	223,226	58,963	0	13,282	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	191,854	164,946	0	37,156	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	517,483	283,055	37,337	63,762	436,968	30.00
43.00	04300	NURSERY	91,990	16,844	12,287	3,794	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	361,778	350,045	10,209	78,853	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	253,185	215,021	32,409	48,436	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	367,928	249,221	8,844	56,140	0	54.00
60.00	06000	LABORATORY	450,059	88,170	0	19,861	0	60.00
65.00	06500	RESPIRATORY THERAPY	141,826	59,420	0	13,385	0	65.00
66.00	06600	PHYSICAL THERAPY	75,554	95,906	7,776	21,604	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,257	6,182	475	1,392	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,291	4,901	178	1,104	0	68.00
69.00	06900	ELECTROCARDIOLOGY	84,191	59,877	10,803	13,488	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,198	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,147	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	22,074	39,357	5,520	8,866	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	124,273	71,710	0	16,154	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,850	7,151	0	1,611	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	615,378	159,880	33,952	36,015	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,716,556	2,334,228	159,790	505,033	436,968	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	686	11,430	0	2,575	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,960	340,170	0	76,628	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	93,042	0	0	0	0	194.00
194.01	07951	FOUNDATION	15,457	4,115	0	927	0	194.01
194.02	07952	COMMUNITY OUTREACH	39	32,243	0	7,263	0	194.02
194.03	07953	WIC	39	30,634	0	6,901	0	194.03
194.04	07954	GRANTS	2,894	17,722	0	3,992	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	2,097	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,843,770	2,770,542	159,790	603,319	436,968	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/27/2017 4:56 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	518,914					11.00
13.00	01300	NURSING ADMINISTRATION	16,832	528,673				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,185	0	313,795			14.00
15.00	01500	PHARMACY	13,042	0	0	1,089,220		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,418	0	0	0	1,112,362	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,303	196,821	16,539	0	43,873	30.00
43.00	04300	NURSERY	16,385	28,974	4,782	0	12,895	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,274	95,974	88,788	0	264,519	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,271	76,517	12,629	0	34,055	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,031	0	12,578	0	267,850	54.00
60.00	06000	LABORATORY	0	0	0	0	200,443	60.00
65.00	06500	RESPIRATORY THERAPY	25,719	0	0	0	15,299	65.00
66.00	06600	PHYSICAL THERAPY	13,978	0	0	0	28,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	492	0	0	0	1,809	67.00
68.00	06800	SPEECH PATHOLOGY	185	0	0	0	623	68.00
69.00	06900	ELECTROCARDIOLOGY	16,272	0	0	0	31,129	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	73,923	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	83,762	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,089,220	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	4,544	0	0	0	7,418	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	19,489	76.00
76.97	07697	CARDIAC REHABILITATION	1,648	0	0	0	3,721	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	73,735	130,387	20,794	0	181,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	514,314	528,673	313,795	1,089,220	1,112,362	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	4,600	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	518,914	528,673	313,795	1,089,220	1,112,362	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/27/2017 4:56 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,516,978	0	3,516,978		30.00
43.00	04300	NURSERY	509,674	0	509,674		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,569,718	0	2,569,718		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,601,007	0	1,601,007		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,313,376	0	2,313,376		54.00
60.00	06000	LABORATORY	2,332,561	0	2,332,561		60.00
65.00	06500	RESPIRATORY THERAPY	751,668	0	751,668		65.00
66.00	06600	PHYSICAL THERAPY	507,093	0	507,093		66.00
67.00	06700	OCCUPATIONAL THERAPY	42,989	0	42,989		67.00
68.00	06800	SPEECH PATHOLOGY	26,290	0	26,290		68.00
69.00	06900	ELECTROCARDIOLOGY	510,208	0	510,208		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	295,185	0	295,185		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,286	0	318,286		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,089,220	0	1,089,220		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	164,981	0	164,981		75.01
76.00	03950	SENIOR RENEWAL CENTER	666,258	0	666,258		76.00
76.97	07697	CARDIAC REHABILITATION	53,933	0	53,933		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,403,560	0	3,403,560		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,672,985	0	20,672,985		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,091	0	17,091		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	475,085	0	475,085		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MARKETING	418,446	0	418,446		194.00
194.01	07951	FOUNDATION	79,159	0	79,159		194.01
194.02	07952	COMMUNITY OUTREACH	39,681	0	39,681		194.02
194.03	07953	WIC	37,709	0	37,709		194.03
194.04	07954	GRANTS	34,731	0	34,731		194.04
194.05	07955	VACANT SPACE	0	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	9,431	0	9,431		194.06
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	21,784,318	0	21,784,318		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 4:56 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,408	1,550	2,958	2,958	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	404,077	30,806	33,930	468,813	575	5.00
7.00	00700	OPERATION OF PLANT	0	43,358	47,755	91,113	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,575	5,039	9,614	0	8.00
9.00	00900	HOUSEKEEPING	0	4,645	5,116	9,761	0	9.00
10.00	01000	DIETARY	0	15,331	16,885	32,216	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,191	5,718	10,909	92	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,595	11,669	22,264	29	14.00
15.00	01500	PHARMACY	34,566	5,893	6,491	46,950	85	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,486	18,158	34,644	154	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,948	28,291	31,160	102,399	502	30.00
43.00	04300	NURSERY	0	1,684	1,854	3,538	82	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94,316	34,987	38,534	167,837	257	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,491	23,670	45,161	217	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	223,589	24,909	27,435	275,933	282	54.00
60.00	06000	LABORATORY	0	8,812	9,706	18,518	0	60.00
65.00	06500	RESPIRATORY THERAPY	318	5,939	6,541	12,798	143	65.00
66.00	06600	PHYSICAL THERAPY	0	9,586	10,558	20,144	59	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	618	680	1,298	6	67.00
68.00	06800	SPEECH PATHOLOGY	0	490	540	1,030	4	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,985	6,591	12,576	93	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	40	3,934	4,333	8,307	20	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	7,167	7,894	15,061	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	715	787	1,502	8	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	15,980	17,600	33,580	334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	799,854	308,876	340,194	1,448,924	2,942	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,142	1,258	2,400	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,570	23,757	45,327	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	411	453	864	16	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	7,334	0	0	7,334	0	194.06
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	807,188	331,999	365,662	1,504,849	2,958	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 4:56 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	469,388					5.00
7.00	00700	OPERATION OF PLANT	59,696	150,809				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,457	2,492	14,563			8.00
9.00	00900	HOUSEKEEPING	11,998	2,530	0	24,289		9.00
10.00	01000	DIETARY	5,366	8,349	0	1,391	47,322	10.00
11.00	01100	CAFETERIA	11,181	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,657	2,827	0	471	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,722	5,770	0	961	0	14.00
15.00	01500	PHARMACY	21,632	3,210	0	535	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,592	8,979	0	1,496	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,147	15,408	3,403	2,567	47,322	30.00
43.00	04300	NURSERY	8,914	917	1,120	153	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,058	19,055	930	3,174	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,535	11,704	2,954	1,950	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,654	13,566	806	2,260	0	54.00
60.00	06000	LABORATORY	43,613	4,799	0	800	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,744	3,234	0	539	0	65.00
66.00	06600	PHYSICAL THERAPY	7,322	5,220	709	870	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	703	336	43	56	0	67.00
68.00	06800	SPEECH PATHOLOGY	416	267	16	44	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,159	3,259	985	543	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,768	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,053	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	2,139	2,142	503	357	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	12,043	3,903	0	650	0	76.00
76.97	07697	CARDIAC REHABILITATION	858	389	0	65	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	59,634	8,703	3,094	1,450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	457,061	127,059	14,563	20,332	47,322	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	66	622	0	104	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,256	18,517	0	3,085	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	9,016	0	0	0	0	194.00
194.01	07951	FOUNDATION	1,498	224	0	37	0	194.01
194.02	07952	COMMUNITY OUTREACH	4	1,755	0	292	0	194.02
194.03	07953	WIC	4	1,667	0	278	0	194.03
194.04	07954	GRANTS	280	965	0	161	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	203	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	469,388	150,809	14,563	24,289	47,322	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 4:56 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	11,181					11.00
13.00	01300	NURSING ADMINISTRATION	363	24,319				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	241	0	32,987			14.00
15.00	01500	PHARMACY	281	0	0	72,693		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,022	0	0	0	64,887	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,397	9,053	1,739	0	2,559	30.00
43.00	04300	NURSERY	353	1,333	503	0	752	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,169	4,415	9,333	0	15,426	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	932	3,520	1,328	0	1,986	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,380	0	1,322	0	15,636	54.00
60.00	06000	LABORATORY	0	0	0	0	11,690	60.00
65.00	06500	RESPIRATORY THERAPY	554	0	0	0	892	65.00
66.00	06600	PHYSICAL THERAPY	301	0	0	0	1,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	11	0	0	0	105	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	0	0	36	68.00
69.00	06900	ELECTROCARDIOLOGY	351	0	0	0	1,815	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	7,771	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	8,805	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	72,693	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	98	0	0	0	433	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	1,137	76.00
76.97	07697	CARDIAC REHABILITATION	36	0	0	0	217	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,589	5,998	2,186	0	10,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,082	24,319	32,987	72,693	64,887	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	99	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,181	24,319	32,987	72,693	64,887	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/27/2017 4:56 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	237,496	0	237,496		30.00
43.00	04300	NURSERY	17,665	0	17,665		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	256,654	0	256,654		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	94,287	0	94,287		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	346,839	0	346,839		54.00
60.00	06000	LABORATORY	79,420	0	79,420		60.00
65.00	06500	RESPIRATORY THERAPY	31,904	0	31,904		65.00
66.00	06600	PHYSICAL THERAPY	36,260	0	36,260		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,558	0	2,558		67.00
68.00	06800	SPEECH PATHOLOGY	1,817	0	1,817		68.00
69.00	06900	ELECTROCARDIOLOGY	27,781	0	27,781		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,539	0	12,539		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,858	0	13,858		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,693	0	72,693		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	13,999	0	13,999		75.01
76.00	03950	SENIOR RENEWAL CENTER	32,794	0	32,794		76.00
76.97	07697	CARDIAC REHABILITATION	3,075	0	3,075		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	127,136	0	127,136		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,408,775	0	1,408,775		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,192	0	3,192		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	68,185	0	68,185		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MARKETING	9,016	0	9,016		194.00
194.01	07951	FOUNDATION	2,738	0	2,738		194.01
194.02	07952	COMMUNITY OUTREACH	2,051	0	2,051		194.02
194.03	07953	WIC	1,949	0	1,949		194.03
194.04	07954	GRANTS	1,406	0	1,406		194.04
194.05	07955	VACANT SPACE	0	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	7,537	0	7,537		194.06
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,504,849	0	1,504,849		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 4:56 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	181,625					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		181,625				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	770	770	7,098,381			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,853	16,853	1,385,937	-4,843,770	16,940,548	5.00
7.00	00700	OPERATION OF PLANT	23,720	23,720	0	0	2,154,513	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,503	2,503	0	0	88,662	8.00
9.00	00900	HOUSEKEEPING	2,541	2,541	0	0	433,031	9.00
10.00	01000	DIETARY	8,387	8,387	0	0	193,656	10.00
11.00	01100	CAFETERIA	0	0	0	0	403,533	11.00
13.00	01300	NURSING ADMINISTRATION	2,840	2,840	221,591	0	348,543	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,796	5,796	68,892	0	134,323	14.00
15.00	01500	PHARMACY	3,224	3,224	203,392	0	780,707	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,019	9,019	369,033	0	670,988	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,477	15,477	1,202,772	0	1,809,837	30.00
43.00	04300	NURSERY	921	921	197,108	0	321,723	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,140	19,140	616,493	0	1,265,278	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,757	11,757	520,560	0	885,484	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,627	13,627	675,486	0	1,286,784	54.00
60.00	06000	LABORATORY	4,821	4,821	0	0	1,574,028	60.00
65.00	06500	RESPIRATORY THERAPY	3,249	3,249	342,793	0	496,019	65.00
66.00	06600	PHYSICAL THERAPY	5,244	5,244	140,602	0	264,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	338	338	14,962	0	25,382	67.00
68.00	06800	SPEECH PATHOLOGY	268	268	10,025	0	15,008	68.00
69.00	06900	ELECTROCARDIOLOGY	3,274	3,274	222,613	0	294,448	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	172,064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	182,377	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	2,152	2,152	48,375	0	77,202	75.01
76.00	03950	SENIOR RENEWAL CENTER	3,921	3,921	0	0	434,632	76.00
76.97	07697	CARDIAC REHABILITATION	391	391	18,238	0	30,952	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,742	8,742	801,663	0	2,152,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	168,975	168,975	7,060,535	-4,843,770	16,495,629	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	625	0	0	2,400	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,800	11,800	0	0	45,327	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	325,404	194.00
194.01	07951	FOUNDATION	225	225	37,846	0	54,060	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	136	194.02
194.03	07953	WIC	0	0	0	0	135	194.03
194.04	07954	GRANTS	0	0	0	0	10,123	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	7,334	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	331,999	365,662	2,798,756		4,843,770	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.827937	2.013280	0.394281		0.285928	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,958		469,388	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000417		0.027708	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 4:56 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (PAID HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	151,489					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,503	2,692				8.00
9.00	00900	HOUSEKEEPING	2,541	0	146,445			9.00
10.00	01000	DIETARY	8,387	0	8,387	1,416		10.00
11.00	01100	CAFETERIA	0	0	0	0	196,193	11.00
13.00	01300	NURSING ADMINISTRATION	2,840	0	2,840	0	6,364	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,796	0	5,796	0	4,229	14.00
15.00	01500	PHARMACY	3,224	0	3,224	0	4,931	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,019	0	9,019	0	17,928	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,477	629	15,477	1,416	42,082	30.00
43.00	04300	NURSERY	921	207	921	0	6,195	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,140	172	19,140	0	20,520	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,757	546	11,757	0	16,360	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,627	149	13,627	0	24,209	54.00
60.00	06000	LABORATORY	4,821	0	4,821	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,249	0	3,249	0	9,724	65.00
66.00	06600	PHYSICAL THERAPY	5,244	131	5,244	0	5,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	338	8	338	0	186	67.00
68.00	06800	SPEECH PATHOLOGY	268	3	268	0	70	68.00
69.00	06900	ELECTROCARDIOLOGY	3,274	182	3,274	0	6,152	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	2,152	93	2,152	0	1,718	75.01
76.00	03950	SENIOR RENEWAL CENTER	3,921	0	3,921	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	391	0	391	0	623	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,742	572	8,742	0	27,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	127,632	2,692	122,588	1,416	194,454	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	0	625	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,600	0	18,600	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	225	0	225	0	1,739	194.01
194.02	07952	COMMUNITY OUTREACH	1,763	0	1,763	0	0	194.02
194.03	07953	WIC	1,675	0	1,675	0	0	194.03
194.04	07954	GRANTS	969	0	969	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,770,542	159,790	603,319	436,968	518,914	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.288734	59.357355	4.119765	308.593220	2.644916	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	150,809	14,563	24,289	47,322	11,181	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.995511	5.409733	0.165857	33.419492	0.056990	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 4:56 pm

		Cost Center Description	NURSING ADMINISTRATION (PAID HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	113,035					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	683,232				14.00
15.00	01500	PHARMACY	0	0	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	51,567,458		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,082	36,011	0	2,033,896		30.00
43.00	04300	NURSERY	6,195	10,412	0	597,776		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,520	193,317	0	12,262,706		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,360	27,498	0	1,578,717		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,386	0	12,417,172		54.00
60.00	06000	LABORATORY	0	0	0	9,292,246		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	709,235		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,299,637		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	83,849		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	28,885		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,443,076		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	160,955	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	182,377	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,000	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0	0	343,907		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	903,462		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	172,485		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	27,878	45,276	0	8,400,409		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	113,035	683,232	10,000	51,567,458		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0		194.02
194.03	07953	WIC	0	0	0	0		194.03
194.04	07954	GRANTS	0	0	0	0		194.04
194.05	07955	VACANT SPACE	0	0	0	0		194.05
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0		194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	528,673	313,795	1,089,220	1,112,362		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.677073	0.459280	108.922000	0.021571		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,319	32,987	72,693	64,887		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.215146	0.048281	7.269300	0.001258		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,516,978		3,516,978	0	0	30.00
43.00	04300	NURSERY	509,674		509,674	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,569,718		2,569,718	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,601,007		1,601,007	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,313,376		2,313,376	0	0	54.00
60.00	06000	LABORATORY	2,332,561		2,332,561	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	751,668	0	751,668	0	0	65.00
66.00	06600	PHYSICAL THERAPY	507,093	0	507,093	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,989	0	42,989	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,290	0	26,290	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	510,208		510,208	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	295,185		295,185	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,286		318,286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,089,220		1,089,220	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	164,981		164,981	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	666,258		666,258	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	53,933		53,933	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,403,560		3,403,560	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	566,244		566,244		0	92.00
200.00		Subtotal (see instructions)	21,239,229	0	21,239,229	0	0	200.00
201.00		Less Observation Beds	566,244		566,244		0	201.00
202.00		Total (see instructions)	20,672,985	0	20,672,985	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,816,884		1,816,884			30.00
43.00	04300	NURSERY	597,776		597,776			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,881,419	9,381,287	12,262,706	0.209556	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,294,212	284,505	1,578,717	1.014119	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,700	11,942,472	12,417,172	0.186305	0.000000	54.00
60.00	06000	LABORATORY	819,974	8,472,272	9,292,246	0.251022	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	317,625	391,610	709,235	1.059829	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	254,512	1,045,125	1,299,637	0.390180	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,800	62,049	83,849	0.512695	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	28,885	28,885	0.910161	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	156,905	1,286,171	1,443,076	0.353556	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	618,711	1,047,312	1,666,023	0.177179	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	369,698	252,935	622,633	0.511194	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,149,299	1,341,719	2,491,018	0.437259	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	343,907	343,907	0.479726	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	903,462	903,462	0.737450	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	172,485	172,485	0.312682	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	151,112	8,249,297	8,400,409	0.405166	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,523	206,489	217,012	2.609275	0.000000	92.00
200.00		Subtotal (see instructions)	10,935,150	45,411,982	56,347,132			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,935,150	45,411,982	56,347,132			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SLEEP DISORDER	0.000000		75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 4:56 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,516,978		3,516,978	0	3,516,978	30.00
43.00	04300	NURSERY	509,674		509,674	0	509,674	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,569,718		2,569,718	0	2,569,718	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,601,007		1,601,007	0	1,601,007	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,313,376		2,313,376	0	2,313,376	54.00
60.00	06000	LABORATORY	2,332,561		2,332,561	0	2,332,561	60.00
65.00	06500	RESPIRATORY THERAPY	751,668	0	751,668	0	751,668	65.00
66.00	06600	PHYSICAL THERAPY	507,093	0	507,093	0	507,093	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,989	0	42,989	0	42,989	67.00
68.00	06800	SPEECH PATHOLOGY	26,290	0	26,290	0	26,290	68.00
69.00	06900	ELECTROCARDIOLOGY	510,208		510,208	0	510,208	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	295,185		295,185	0	295,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,286		318,286	0	318,286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,089,220		1,089,220	0	1,089,220	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	164,981		164,981	0	164,981	75.01
76.00	03950	SENIOR RENEWAL CENTER	666,258		666,258	0	666,258	76.00
76.97	07697	CARDIAC REHABILITATION	53,933		53,933	0	53,933	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,403,560		3,403,560	0	3,403,560	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	566,244		566,244		566,244	92.00
200.00		Subtotal (see instructions)	21,239,229	0	21,239,229	0	21,239,229	200.00
201.00		Less Observation Beds	566,244		566,244		566,244	201.00
202.00		Total (see instructions)	20,672,985	0	20,672,985	0	20,672,985	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 4:56 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,816,884		1,816,884			30.00
43.00	04300	NURSERY	597,776		597,776			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,881,419	9,381,287	12,262,706	0.209556	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,294,212	284,505	1,578,717	1.014119	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,700	11,942,472	12,417,172	0.186305	0.000000	54.00
60.00	06000	LABORATORY	819,974	8,472,272	9,292,246	0.251022	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	317,625	391,610	709,235	1.059829	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	254,512	1,045,125	1,299,637	0.390180	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,800	62,049	83,849	0.512695	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	28,885	28,885	0.910161	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	156,905	1,286,171	1,443,076	0.353556	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	618,711	1,047,312	1,666,023	0.177179	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	369,698	252,935	622,633	0.511194	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,149,299	1,341,719	2,491,018	0.437259	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	343,907	343,907	0.479726	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	903,462	903,462	0.737450	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	172,485	172,485	0.312682	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	151,112	8,249,297	8,400,409	0.405166	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,523	206,489	217,012	2.609275	0.000000	92.00
200.00		Subtotal (see instructions)	10,935,150	45,411,982	56,347,132			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,935,150	45,411,982	56,347,132			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1335	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/27/2017 4:56 pm
	Title XIX	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SLEEP DISORDER	0.000000		75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	256,654	12,262,706	0.020930	753,880	15,779	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	94,287	1,578,717	0.059724	9,022	539	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	346,839	12,417,172	0.027932	196,653	5,493	54.00
60.00	06000	LABORATORY	79,420	9,292,246	0.008547	294,791	2,520	60.00
65.00	06500	RESPIRATORY THERAPY	31,904	709,235	0.044984	102,142	4,595	65.00
66.00	06600	PHYSICAL THERAPY	36,260	1,299,637	0.027900	85,701	2,391	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,558	83,849	0.030507	3,110	95	67.00
68.00	06800	SPEECH PATHOLOGY	1,817	28,885	0.062905	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	27,781	1,443,076	0.019251	145,803	2,807	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,539	1,666,023	0.007526	290,019	2,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,858	622,633	0.022257	218,117	4,855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,693	2,491,018	0.029182	543,539	15,862	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	13,999	343,907	0.040706	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	32,794	903,462	0.036298	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,075	172,485	0.017828	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	127,136	8,400,409	0.015135	4,793	73	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	38,237	217,012	0.176198	294	52	92.00
200.00		Total (lines 50-199)	1,191,851	53,932,472		2,647,864	57,244	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,262,706	0.000000	0.000000	753,880	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,578,717	0.000000	0.000000	9,022	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,417,172	0.000000	0.000000	196,653	54.00
60.00	06000	LABORATORY	0	9,292,246	0.000000	0.000000	294,791	60.00
65.00	06500	RESPIRATORY THERAPY	0	709,235	0.000000	0.000000	102,142	65.00
66.00	06600	PHYSICAL THERAPY	0	1,299,637	0.000000	0.000000	85,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	83,849	0.000000	0.000000	3,110	67.00
68.00	06800	SPEECH PATHOLOGY	0	28,885	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,443,076	0.000000	0.000000	145,803	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,666,023	0.000000	0.000000	290,019	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	622,633	0.000000	0.000000	218,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,491,018	0.000000	0.000000	543,539	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	0	343,907	0.000000	0.000000	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	903,462	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	172,485	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	8,400,409	0.000000	0.000000	4,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	217,012	0.000000	0.000000	294	92.00
200.00		Total (lines 50-199)	0	53,932,472			2,647,864	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.209556	0	2,993,789	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.014119	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186305	0	3,496,655	0	0	54.00
60.00	06000	LABORATORY	0.251022	0	2,405,812	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.059829	0	31,372	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.390180	0	321,722	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512695	0	9,206	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.910161	0	686	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.353556	0	518,157	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.177179	0	332,650	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.511194	0	83,787	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437259	0	360,696	8,347	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.479726	0	88,435	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.737450	0	826,895	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.312682	0	154,668	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.405166	0	2,151,558	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.609275	0	119,597	0	0	92.00
200.00		Subtotal (see instructions)		0	13,895,685	8,347	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	13,895,685	8,347	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	627,366	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	651,444	0		54.00
60.00	06000	LABORATORY	603,912	0		60.00
65.00	06500	RESPIRATORY THERAPY	33,249	0		65.00
66.00	06600	PHYSICAL THERAPY	125,529	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,720	0		67.00
68.00	06800	SPEECH PATHOLOGY	624	0		68.00
69.00	06900	ELECTROCARDIOLOGY	183,198	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,939	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,831	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,718	3,650		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	42,425	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	609,794	0		76.00
76.97	07697	CARDIAC REHABILITATION	48,362	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	871,738	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	312,061	0		92.00
200.00		Subtotal (see instructions)	4,373,910	3,650		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,373,910	3,650		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.209556	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.014119	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186305	0	0	0	0	54.00
60.00	06000	LABORATORY	0.251022	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.059829	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.390180	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512695	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.910161	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.353556	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.177179	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.511194	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437259	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.479726	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.737450	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.312682	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.405166	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.609275	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part III Date/Time Prepared: 11/27/2017 4:56 pm

Title XIX | Hospital | Cost

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,735	0.00	33	0		30.00
43.00	04300	NURSERY	642	0.00	25	0		43.00
200.00		Total (lines 30-199)	2,377		58	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 4:56 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 4:56 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	12,262,706	0.000000	0.000000	74,884	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,578,717	0.000000	0.000000	77,403	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,417,172	0.000000	0.000000	21,788	54.00
60.00	06000	LABORATORY	0	9,292,246	0.000000	0.000000	29,728	60.00
65.00	06500	RESPIRATORY THERAPY	0	709,235	0.000000	0.000000	14,401	65.00
66.00	06600	PHYSICAL THERAPY	0	1,299,637	0.000000	0.000000	2,258	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	83,849	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	28,885	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,443,076	0.000000	0.000000	805	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,666,023	0.000000	0.000000	17,227	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	622,633	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,491,018	0.000000	0.000000	38,675	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	0	343,907	0.000000	0.000000	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	903,462	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	172,485	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	8,400,409	0.000000	0.000000	18,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	217,012	0.000000	0.000000	865	92.00
200.00		Total (lines 50-199)	0	53,932,472			296,640	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/27/2017 4:56 pm

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,021	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,735	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,416	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	122	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)	121	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	22	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)	21	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	984	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)	107	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)	109	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,516,978	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)	3,021	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)	2,884	25.00
26.00	Total swing-bed cost (see instructions)	437,245	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,079,733	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,079,733	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,775.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,746,659	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)	1,746,659	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	875,862	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,622,521	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)	189,931	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	193,482	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	383,413	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)	319	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,775.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	566,244	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	237,496	3,516,978	0.067528	566,244	38,237	90.00
91.00	Nursing School cost	0	3,516,978	0.000000	566,244	0	91.00
92.00	Allied health cost	0	3,516,978	0.000000	566,244	0	92.00
93.00	All other Medical Education	0	3,516,978	0.000000	566,244	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 4:56 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,021	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,735	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,416	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	122	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)	121	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	22	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)	21	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	33	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)	642	15.00
16.00	Nursery days (title V or XIX only)	25	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,516,978	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)	3,021	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)	2,884	25.00
26.00	Total swing-bed cost (see instructions)	437,245	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,079,733	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,079,733	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,775.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	58,577	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)	58,577	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 4:56 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)	509,674	642	793.88	25	19,847	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)	151,897	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	230,321	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)	319	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,775.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	566,244	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 4:56 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	237,496	3,516,978	0.067528	566,244	38,237	90.00
91.00	Nursing School cost	0	3,516,978	0.000000	566,244	0	91.00
92.00	Allied health cost	0	3,516,978	0.000000	566,244	0	92.00
93.00	All other Medical Education	0	3,516,978	0.000000	566,244	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		754,610		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209556	753,880	157,980	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.014119	9,022	9,149	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186305	196,653	36,637	54.00
60.00	06000	LABORATORY	0.251022	294,791	73,999	60.00
65.00	06500	RESPIRATORY THERAPY	1.059829	102,142	108,253	65.00
66.00	06600	PHYSICAL THERAPY	0.390180	85,701	33,439	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512695	3,110	1,594	67.00
68.00	06800	SPEECH PATHOLOGY	0.910161	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.353556	145,803	51,550	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.177179	290,019	51,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.511194	218,117	111,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437259	543,539	237,667	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	0.479726	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.737450	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.312682	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.405166	4,793	1,942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.609275	294	767	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,647,864	875,862	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,647,864		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209556	814	171	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.014119	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186305	3,344	623	54.00
60.00	06000	LABORATORY	0.251022	20,877	5,241	60.00
65.00	06500	RESPIRATORY THERAPY	1.059829	10,106	10,711	65.00
66.00	06600	PHYSICAL THERAPY	0.390180	97,059	37,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512695	13,025	6,678	67.00
68.00	06800	SPEECH PATHOLOGY	0.910161	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.353556	10,297	3,641	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.177179	41,252	7,309	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.511194	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437259	67,512	29,520	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	0.479726	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.737450	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.312682	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.405166	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.609275	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		264,286	101,764	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)		264,286		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/27/2017 4:56 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		42,184		30.00
43.00	04300	NURSERY		29,309		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209556	74,884	15,692	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.014119	77,403	78,496	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186305	21,788	4,059	54.00
60.00	06000	LABORATORY	0.251022	29,728	7,462	60.00
65.00	06500	RESPIRATORY THERAPY	1.059829	14,401	15,263	65.00
66.00	06600	PHYSICAL THERAPY	0.390180	2,258	881	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512695	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.910161	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.353556	805	285	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.177179	17,227	3,052	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.511194	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437259	38,675	16,911	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	0.479726	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.737450	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.312682	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.405166	18,606	7,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.609275	865	2,257	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		296,640	151,897	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)		296,640		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1335	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/27/2017 4:56 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,377,560	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,377,560	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,421,336	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	41,889	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,304,718	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)	2,074,729	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)	2,074,729	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,074,729	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)	485,210	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	315,387	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	376,770	36.00
37.00	Subtotal (see instructions)	2,390,116	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,390,116	40.00
40.01	Sequestration adjustment (see instructions)	47,802	40.01
41.00	Interim payments	2,050,444	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	291,870	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,940,162		1,989,444	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/27/2016	229,500	12/27/2016	61,000	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)		229,500		61,000	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,169,662		2,050,444	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		217,185		291,870	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,386,847		2,342,314	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/27/2017 4:56 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		359,199		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		359,199		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		119,767		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		478,966		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1335	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/27/2017 4:56 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	409	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	984	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	167	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,416	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	56,347,132	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,586,428	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1335 Component CCN: 15-Z335	Period: From 07/01/2016 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 11/27/2017 4:56 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	387,247	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	102,782	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	216	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	490,029	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	490,029	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	490,029	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,288	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	488,741	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	488,741	0	19.00
19.01	Sequestration adjustment (see instructions)	9,775	0	19.01
20.00	Interim payments	359,199	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	119,767	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1335	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/27/2017 4:56 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,622,521	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,622,521	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,648,746	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,648,746	19.00
20.00	Deductibles (exclude professional component)	237,972	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,410,774	22.00
23.00	Coinsurance	1,288	23.00
24.00	Subtotal (line 22 minus line 23)	2,409,486	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	40,110	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	26,072	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,375	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,435,558	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,435,558	30.00
30.01	Sequestration adjustment (see instructions)	48,711	30.01
31.00	Interim payments	2,169,662	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	217,185	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1335	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/27/2017 4:56 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	230,321		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)	230,321	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)	230,321	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	42,184		8.00
9.00	Ancillary service charges	296,640	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)	338,824	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)	338,824	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	108,503	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)	230,321	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)	230,321	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)	230,321	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)	230,321	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	230,321	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)	230,321	0	40.00
41.00	Interim payments	230,321	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/27/2017 4:56 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	41,855	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	4,355,169	0	0	0	4.00
5.00	Other receivable	604,726	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,221,618	0	0	0	6.00
7.00	Inventory	504,909	0	0	0	7.00
8.00	Prepaid expenses	9,707	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)	3,294,748	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	100,000	0	0	0	12.00
13.00	Land improvements	83,405	0	0	0	13.00
14.00	Accumulated depreciation	-46,655	0	0	0	14.00
15.00	Buildings	5,546,056	0	0	0	15.00
16.00	Accumulated depreciation	-1,793,487	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,687,940	0	0	0	19.00
20.00	Accumulated depreciation	-1,255,566	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,592,084	0	0	0	23.00
24.00	Accumulated depreciation	-2,883,322	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,030,455	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,142	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,142	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,331,345	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	987,909	0	0	0	37.00
38.00	Salaries, wages, and fees payable	861,775	0	0	0	38.00
39.00	Payroll taxes payable	71,086	0	0	0	39.00
40.00	Notes and loans payable (short term)	98,463	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	3,087,233	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,106,466	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,303,413	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,303,413	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,409,879	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-3,078,534				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)	-3,078,534	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,331,345	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/27/2017 4:56 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		8,081,233		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,786,503				2.00
3.00	Total (sum of line 1 and line 2)		9,867,736		0		3.00
4.00	OTHER RESTRICTED ACTIVITY	0		0		0	4.00
5.00	GRANT REVENUE - FEDERAL	0		0		0	5.00
6.00	TRANSFER FROM AFFILIATES	0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00	ROUNDING	4		0		0	9.00
10.00	Total additions (sum of line 4-9)		4		0		10.00
11.00	Subtotal (line 3 plus line 10)		9,867,740		0		11.00
12.00	TRANSFER FROM AFFILIATES	12,919,210		0		0	12.00
13.00	OTHER UNRESTRICTED ACTIVITY	50,064		0		0	13.00
14.00	DEFERRED PENSION COSTS ADMINISTERED	0		0		0	14.00
15.00	NET ASSETS RELEASED FROM RESTRICTION	-23,000		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)		12,946,274		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-3,078,534		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	OTHER RESTRICTED ACTIVITY		0			4.00
5.00	GRANT REVENUE - FEDERAL		0			5.00
6.00	TRANSFER FROM AFFILIATES		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00	ROUNDING		0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFER FROM AFFILIATES		0			12.00
13.00	OTHER UNRESTRICTED ACTIVITY		0			13.00
14.00	DEFERRED PENSION COSTS ADMINISTERED		0			14.00
15.00	NET ASSETS RELEASED FROM RESTRICTION		0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/27/2017 4:56 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,194,342		4,194,342	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,194,342		4,194,342	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,194,342		4,194,342	17.00
18.00	Ancillary services	7,030,854	36,589,328	43,620,182	18.00
19.00	Outpatient services	161,635	8,370,975	8,532,610	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	COMMUNITY OUTREACH	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,386,831	44,960,303	56,347,134	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,240,493		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,240,493		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1335	Period: From 07/01/2016 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/27/2017 4:56 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,347,134	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,909,360	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,437,774	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,240,493	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,197,281	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,043	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	70,182	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	6,274	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	60,305	22.00
23.00	Governmental appropriations	5,436	23.00
24.00	OTHER	15,031	24.00
24.01	LOSS ON INTEREST RATE SWAPS	6,323	24.01
24.02	MEDICAL STAFF DUES	4,161	24.02
24.03	STATE PROGRAM REVENUE	393,834	24.03
24.04	FOUNDATION	26,633	24.04
25.00	Total other income (sum of lines 6-24)	589,222	25.00
26.00	Total (line 5 plus line 25)	1,786,503	26.00
27.00	NON-RECURRING EXPENSE	0	27.00
27.01	LOSS ON INTEREST RATE SWAP	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,786,503	29.00