Health Financial Systems | HEART HOSPITAL AT DEACONESS GATEWAY | In Lieu of Form CMS-2552-10

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: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/27/2017 2:45 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/27/2017 Time: 2:45 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 HEART HOSPITAL AT DEACONESS GATEWAY (15-0175) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/27/2017 Time: 2:45 pm
T69:TtLtb8KGeAIE4NMCEnvRJOeJn0
zZUlE00lJw01kS2WrNCkRxwzabwewB
7QTf0N.81r0AW8ar

PI: Date: 2/27/2017 Time: 2:45 pm
ROUh8FkPgZHL4yfR1OMl3Fp1.CCNx0
UPe0b08Vg.jAGjcGJP9T3OCF1cg4qq
wUtr09zEfr0KyW65

(Signed) Rebecca L. Malotte
Officer or Administrator of Provider(s)

EXECUTIVE DIRECTOR & CNO
Title

February 28, 2017
Date

		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	27,589	46,265	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	27,589	46,265	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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2017 2:04 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4007 GATEWAY BOULEVARD	PO Box:			1.00
2.00	City: NEWBURGH	State: IN	Zip Code: 47630-	County: WARRICK	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	HEART HOSPITAL AT DEACONESS GATEWAY	150175	21780	1	02/23/2009	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2015	09/30/2016	20.00
21.00	Type of Control (see instructions)	4		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.	3	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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 2:04 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			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)				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

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		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	0	0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 2:04 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	0	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)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	6,876	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.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 2:04 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	HB0778	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: DEACONESS HEALTH SYSTEM, INC	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	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)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 2:04 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)	10/03/2016	12/31/2016	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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 2:04 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.	Y			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)	N		N		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)	Y	02/01/2017	Y	02/01/2017	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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 2:04 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		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		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.		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.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y		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.	DANIELLE	METZGER-CUNDIFF	41.00
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(812) 450-7423	DANIELLE.METZGER-CUNDIFF@DEACONESS.C	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 2:04 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 ANALYST		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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2017 2:04 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	24	8,784	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		24	8,784	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		24	8,784	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		24				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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2017 2:04 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)	3,282	97	6,208			1.00
2.00	HMO and other (see instructions)	865	191				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,282	97	6,208			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)	3,282	97	6,208	0.00	144.50	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	144.50	27.00
28.00	Observation Bed Days		77	718			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2017 2:04 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	849	23	1,590	1.00
2.00	HMO and other (see instructions)			182	49		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	849	23	1,590	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 WAGE INDEX INFORMATION | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/27/2017 2:04 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	9,200,808	36,524	9,237,332	300,413.00	30.75	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		105,385	0	105,385	2,080.00	50.67	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		749	0	749	25.00	29.96	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		984,003	0	984,003	11,590.00	84.90	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		45,535	0	45,535	319.00	142.74	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		85,958	0	85,958	2,943.00	29.21	14.00
14.01	Home office salaries		1,529,314	0	1,529,314	85,433.00	17.90	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,634,617	0	2,634,617			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		18,271	0	18,271			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	756,959	22,967	779,926	15,484.44	50.37	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/27/2017 2:04 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		159,799	0	159,799	322.35	495.73	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		264,870	0	264,870	16,831.00	15.74	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		115,910	0	115,910	6,403.00	18.10	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 2/27/2017 2:04 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		9,741,387	36,524	9,777,911	323,969.35	30.18	1.00
2.00	Excluded area salaries (see instructions)		749	0	749	25.00	29.96	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,740,638	36,524	9,777,162	323,944.35	30.18	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,644,810	0	2,644,810	100,285.00	26.37	4.00
5.00	Subtotal wage-related costs (see inst.)		2,634,617	0	2,634,617	0.00	26.95	5.00
6.00	Total (sum of lines 3 thru 5)		15,020,065	36,524	15,056,589	424,229.35	35.49	6.00
7.00	Total overhead cost (see instructions)		1,297,538	22,967	1,320,505	39,040.79	33.82	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 2/27/2017 2:04 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	374,225	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	26,393	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	77	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	364	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,207,011	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	49,873	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	3,071	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	8	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	121,483	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	2,998	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	697,900	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	105	19.00
20.00	State or Federal Unemployment Taxes	54,342	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	91,299	22.00
23.00	Tuition Reimbursement	23,739	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,652,888	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 2/27/2017 2:04 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/27/2017 2:04 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)	0.237631	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	967,103	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,542,745	6.00
7.00	Medicaid cost (line 1 times line 6)	2,030,021	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,062,918	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
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,062,918	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	931,837	285,310	1,217,147	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	221,433	67,799	289,232	21.00
22.00	Partial payment by patients approved for charity care	305	0	305	22.00
23.00	Cost of charity care (line 21 minus line 22)	221,128	67,799	288,927	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,115,858	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	68,788	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,047,070	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	248,816	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	537,743	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,600,661	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 2:04 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		0	0	1,724,416	1,724,416	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,611,065	2,611,065	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,054,011	2,054,011	0	2,054,011	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	756,959	7,779,435	8,536,394	-2,772,751	5,763,643	5.00
7.00	00700	OPERATION OF PLANT	0	430,803	430,803	0	430,803	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	108,259	108,259	0	108,259	8.00
9.00	00900	HOUSEKEEPING	0	261,415	261,415	0	261,415	9.00
10.00	01000	DIETARY	0	240,741	240,741	0	240,741	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	76,049	76,049	-285	75,764	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	238,615	238,615	-13,956	224,659	14.00
15.00	01500	PHARMACY	0	2,639,189	2,639,189	-1,884,239	754,950	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	592,609	592,609	0	592,609	16.00
17.00	01700	SOCIAL SERVICE	0	157,659	157,659	0	157,659	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,329,262	1,785,068	5,114,330	-400,675	4,713,655	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	646,217	5,399,546	6,045,763	-1,559,074	4,486,689	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,076	652,360	658,436	0	658,436	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,539,946	11,047,573	13,587,519	-8,365,435	5,222,084	59.00
60.00	06000	LABORATORY	0	1,606,034	1,606,034	-2,063	1,603,971	60.00
64.00	06400	INTRAVENOUS THERAPY	586,521	301,514	888,035	-175,547	712,488	64.00
65.00	06500	RESPIRATORY THERAPY	0	265,389	265,389	-18,213	247,176	65.00
66.00	06600	PHYSICAL THERAPY	0	205,196	205,196	0	205,196	66.00
69.00	06900	ELECTROCARDIOLOGY	818,505	801,918	1,620,423	-264,060	1,356,363	69.00
69.01	06901	CARDIAC REHAB	485,817	172,514	658,331	-15,772	642,559	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,180,238	1,180,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,071,062	8,071,062	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,884,239	1,884,239	73.00
74.00	07400	RENAL DIALYSIS	30,756	34,326	65,082	1,050	66,132	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,200,059	36,850,223	46,050,282	0	46,050,282	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	749	580	1,329	0	1,329	192.00
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	24,929	24,929	0	24,929	194.02
194.03	07953	DEACONESS HOSPITAL	0	39,877	39,877	0	39,877	194.03
200.00		TOTAL (SUM OF LINES 118-199)	9,200,808	36,915,609	46,116,417	0	46,116,417	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 2:04 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	-700,930	1,023,486		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-15	2,611,050		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	768,615	2,822,626		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,589,074	4,174,569		5.00
7.00	00700	OPERATION OF PLANT	-146,276	284,527		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-28,667	79,592		8.00
9.00	00900	HOUSEKEEPING	-181,029	80,386		9.00
10.00	01000	DIETARY	-191,408	49,333		10.00
11.00	01100	CAFETERIA	133,239	133,239		11.00
13.00	01300	NURSING ADMINISTRATION	1,038	76,802		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-153,193	71,466		14.00
15.00	01500	PHARMACY	-691,955	62,995		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-449,787	142,822		16.00
17.00	01700	SOCIAL SERVICE	-31,789	125,870		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,713,655		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,670,306	2,816,383		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-44,877	613,559		54.00
59.00	05900	CARDIAC CATHETERIZATION	-15,983	5,206,101		59.00
60.00	06000	LABORATORY	316,873	1,920,844		60.00
64.00	06400	INTRAVENOUS THERAPY	0	712,488		64.00
65.00	06500	RESPIRATORY THERAPY	364,290	611,466		65.00
66.00	06600	PHYSICAL THERAPY	-75,881	129,315		66.00
69.00	06900	ELECTROCARDIOLOGY	-86,053	1,270,310		69.00
69.01	06901	CARDIAC REHAB	0	642,559		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	307,025	1,487,263		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,071,062		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,884,239		73.00
74.00	07400	RENAL DIALYSIS	-448	65,684		74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,166,591	41,883,691		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,329		192.00
194.00	07954	MISC NONREIMBURSABLE	0	0		194.00
194.01	07951	VISITOR ASSISTANTS	0	0		194.01
194.02	07952	PUBLIC RELATIONS	0	24,929		194.02
194.03	07953	DEACONESS HOSPITAL	0	39,877		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-4,166,591	41,949,826		200.00

RECLASSIFICATIONS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 2:04 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EQUIPMENT DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,688,030	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
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	0		0	1,688,030	
	B - LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,724,416	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	821,848	2.00
3.00		0.00	0	0	3.00
	0		0	2,546,264	
	C - INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	26,477	1.00
2.00		0.00	0	0	2.00
	0		0	26,477	
	D - PROPERTY TAXES				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,503	1.00
2.00		0.00	0	0	2.00
	0		0	15,503	
	E - MEDICAL SUPPLIES AND DRUGS CHARGED				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,180,238	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,071,062	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,884,239	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	0		0	11,135,539	
	F - PROFESSIONAL FEES				
1.00	CARDIAC CATHETERIZATION	59.00	0	39,563	1.00
2.00	RENAL DIALYSIS	74.00	0	1,050	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	1,013	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	41,626	
	G - INCENTIVE COMPENSATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	23,967	13,533	1.00
2.00	ADULTS & PEDIATRICS	30.00	16,662	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	12,366	0	3.00
4.00	INTRAVENOUS THERAPY	64.00	2,019	0	4.00
5.00	ELECTROCARDIOLOGY	69.00	7,253	0	5.00
6.00	CARDIAC REHAB	69.01	5,986	0	6.00
7.00		0.00	0	0	7.00
	0		68,253	13,533	
	H - DISABILITY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,250	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	29,453	2.00
3.00	OPERATING ROOM	50.00	0	759	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	7,504	4.00
5.00	ELECTROCARDIOLOGY	69.00	0	692	5.00
6.00	CARDIAC REHAB	69.01	0	4,846	6.00
	0		0	44,504	
	I - SALARIES IN NON-SALARY ACCOUNTS				
1.00	ADMINISTRATIVE & GENERAL	5.00	250	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	9,985	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	1,055	0	3.00
4.00	INTRAVENOUS THERAPY	64.00	655	0	4.00
5.00	ELECTROCARDIOLOGY	69.00	555	0	5.00
6.00	CARDIAC REHAB	69.01	275	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	0		12,775	0	

RECLASSIFICATIONS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 2:04 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	J - INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	59,207	1.00
2.00		0.00	0	0	2.00
	0		0	59,207	
500.00	Grand Total: Increases		81,028	15,570,683	500.00

RECLASSIFICATIONS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 2:04 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EQUIPMENT DEPRECIATION					
1.00		0.00	0	0	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	42,464	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	285	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	417,337	0	4.00
5.00	OPERATING ROOM	50.00	0	100,868	0	5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	821,787	0	6.00
7.00	INTRAVENOUS THERAPY	64.00	0	12,218	0	7.00
8.00	ELECTROCARDIOLOGY	69.00	0	271,313	0	8.00
9.00	CARDIAC REHAB	69.01	0	21,758	0	9.00
	0		0	1,688,030		
	B - LEASES					
1.00		0.00	0	0	10	1.00
2.00		0.00	0	0	10	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	2,546,264	0	3.00
	0		0	2,546,264		
	C - INSURANCE					
1.00		0.00	0	0	12	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	26,477	0	2.00
	0		0	26,477		
	D - PROPERTY TAXES					
1.00		0.00	0	0	13	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	15,503	0	2.00
	0		0	15,503		
	E - MEDICAL SUPPLIES AND DRUGS CHARGED					
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,956	0	4.00
5.00	PHARMACY	15.00	0	1,884,239	0	5.00
6.00	OPERATING ROOM	50.00	0	1,458,206	0	6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	7,595,577	0	7.00
8.00	INTRAVENOUS THERAPY	64.00	0	165,348	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	18,213	0	9.00
	0		0	11,135,539		
	F - PROFESSIONAL FEES					
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	39,563	0	4.00
5.00	LABORATORY	60.00	0	2,063	0	5.00
	0		0	41,626		
	G - INCENTIVE COMPENSATION					
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	0	81,786	0	7.00
	0		0	81,786		
	H - DISABILITY					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,250	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	29,453	0	0	2.00
3.00	OPERATING ROOM	50.00	759	0	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	7,504	0	0	4.00
5.00	ELECTROCARDIOLOGY	69.00	692	0	0	5.00
6.00	CARDIAC REHAB	69.01	4,846	0	0	6.00
	0		44,504	0		
	I - SALARIES IN NON-SALARY ACCOUNTS					
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	0	250	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	9,985	0	7.00
8.00	CARDIAC CATHETERIZATION	59.00	0	1,055	0	8.00
9.00	INTRAVENOUS THERAPY	64.00	0	655	0	9.00
10.00	ELECTROCARDIOLOGY	69.00	0	555	0	10.00
11.00	CARDIAC REHAB	69.01	0	275	0	11.00
	0		0	12,775		

RECLASSIFICATIONS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 2:04 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - INTEREST EXPENSE						
1.00		0.00	0	0	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	59,207	0		2.00
	0		0	59,207			
500.00	Grand Total: Decreases		44,504	15,607,207			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 2/27/2017 2:04 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	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,598,785	2,035,109	0	2,035,109	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,598,785	2,035,109	0	2,035,109	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,598,785	2,035,109	0	2,035,109	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	14,633,894	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,633,894	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,633,894	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2017 2:04 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	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	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	0		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/27/2017 2:04 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,633,894	0	14,633,894	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	14,633,894	0	14,633,894	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,023,486	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,688,030	821,848	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,688,030	1,845,334	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	0	0	0	0	1,023,486	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	59,192	26,477	15,503	0	2,611,050	2.00
3.00	Total (sum of lines 1-2)	59,192	26,477	15,503	0	3,634,536	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/27/2017 2:04 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-15	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,118	ADMINISTRATIVE & GENERAL	5.00	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	-102,920			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	-3,068,277			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0		0.00	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RESEARCH	A	-420,671	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	HOSPITAL ASSESSMENT FEE	A	-573,590	ADMINISTRATIVE & GENERAL	5.00	0	34.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/27/2017 2:04 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	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,166,591				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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2017 2:04 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	1.00	CAP REL COSTS-BLDG & FIXT	CONTRACTED SERVICES	1,023,486	1,724,416	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CONTRACTED SERVICES	821,848	821,848	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CONTRACTED SERVICES	817,598	48,983	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES	1,805,022	2,398,306	4.00
4.01	7.00	OPERATION OF PLANT	CONTRACTED SERVICES	46,959	193,235	4.01
4.02	8.00	LAUNDRY & LINEN SERVICE	CONTRACTED SERVICES	79,592	108,259	4.02
4.03	9.00	HOUSEKEEPING	CONTRACTED SERVICES	80,386	261,415	4.03
4.04	10.00	DIETARY	CONTRACTED SERVICES	49,333	240,741	4.04
4.05	11.00	CAFETERIA	CONTRACTED SERVICES	133,239	0	4.05
4.06	13.00	NURSING ADMINISTRATION	CONTRACTED SERVICES	76,802	75,764	4.06
4.07	14.00	CENTRAL SERVICES & SUPPLY	CONTRACTED SERVICES	57,109	210,302	4.07
4.08	15.00	PHARMACY	CONTRACTED SERVICES	12,346	704,301	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	CONTRACTED SERVICES	142,822	592,609	4.09
4.10	17.00	SOCIAL SERVICE	CONTRACTED SERVICES	112,324	144,113	4.10
4.11	30.00	ADULTS & PEDIATRICS	CONTRACTED SERVICES	168,007	168,007	4.11
4.12	50.00	OPERATING ROOM	CONTRACTED SERVICES	701,872	2,372,178	4.12
4.13	54.00	RADIOLOGY-DIAGNOSTIC	CONTRACTED SERVICES	394,223	439,100	4.13
4.14	59.00	CARDIAC CATHETERIZATION	CONTRACTED SERVICES	-216,696	-216,696	4.14
4.15	60.00	LABORATORY	CONTRACTED SERVICES	1,918,182	1,601,284	4.15
4.16	64.00	INTRAVENOUS THERAPY	CONTRACTED SERVICES	10,510	10,510	4.16
4.17	65.00	RESPIRATORY THERAPY	CONTRACTED SERVICES	599,398	235,108	4.17
4.18	69.00	ELECTROCARDIOLOGY	CONTRACTED SERVICES	66,140	66,140	4.18
4.19	69.01	CARDIAC REHAB	CONTRACTED SERVICES	-19,752	-19,752	4.19
4.20	71.00	MEDICAL SUPPLIES CHARGED TO	CONTRACTED SERVICES	307,025	0	4.20
4.21	74.00	RENAL DIALYSIS	CONTRACTED SERVICES	51	51	4.21
4.22	66.00	PHYSICAL THERAPY	CONTRACTED SERVICES	129,315	205,196	4.22
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,317,141	12,385,418	5.00

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

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

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

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

6.00	B		51.00	DEACONESS HOSPI	0.00	6.00
7.00	B		51.00	DEACONESS HOSPI	0.00	7.00
8.00	B		51.00	DEACONESS HOSPI	0.00	8.00
9.00	B		51.00	DEACONESS HOSPI	0.00	9.00
10.00	B		51.00	DEACONESS HOSPI	0.00	10.00
10.01	B		51.00	DEACONESS HOSPI	0.00	10.01
10.02	B		51.00	DEACONESS HOSPI	0.00	10.02
10.03	B		51.00	DEACONESS HOSPI	0.00	10.03
10.04	B		51.00	DEACONESS HOSPI	0.00	10.04
10.05	B		51.00	DEACONESS HOSPI	0.00	10.05
10.06	B		51.00	DEACONESS HOSPI	0.00	10.06
10.07	B		51.00	DEACONESS HOSPI	0.00	10.07
10.08	B		51.00	DEACONESS HOSPI	0.00	10.08
10.09	B		51.00	DEACONESS HOSPI	0.00	10.09
10.10	B		51.00	DEACONESS HOSPI	0.00	10.10
10.11	B		51.00	DEACONESS HOSPI	0.00	10.11
10.12	B		51.00	DEACONESS HOSPI	0.00	10.12
10.13	B		51.00	DEACONESS HOSPI	0.00	10.13
10.14	B		51.00	DEACONESS HOSPI	0.00	10.14
10.15	B		51.00	DEACONESS HOSPI	0.00	10.15
10.16	B		51.00	DEACONESS HOSPI	0.00	10.16

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2017 2:04 pm

				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	
10.17	B		51.00	DEACONESS HOSPI	0.00	10.17
10.18	B		51.00	DEACONESS HOSPI	0.00	10.18
10.19	B		51.00	DEACONESS HOSPI	0.00	10.19
10.20	B		51.00	DEACONESS HOSPI	0.00	10.20
10.22	A		0.00	PROGRESSIVE HEA	51.00	10.22
100.00	G. Other (financial or non-financial) specify:					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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2017 2:04 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	-700,930	10		1.00
2.00	0	10		2.00
3.00	768,615	0		3.00
4.00	-593,284	0		4.00
4.01	-146,276	0		4.01
4.02	-28,667	0		4.02
4.03	-181,029	0		4.03
4.04	-191,408	0		4.04
4.05	133,239	0		4.05
4.06	1,038	0		4.06
4.07	-153,193	0		4.07
4.08	-691,955	0		4.08
4.09	-449,787	0		4.09
4.10	-31,789	0		4.10
4.11	0	0		4.11
4.12	-1,670,306	0		4.12
4.13	-44,877	0		4.13
4.14	0	0		4.14
4.15	316,898	0		4.15
4.16	0	0		4.16
4.17	364,290	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	307,025	0		4.20
4.21	0	0		4.21
4.22	-75,881	0		4.22
5.00	-3,068,277			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	HOSPITAL		6.00
7.00	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOSPITAL		9.00
10.00	HOSPITAL		10.00
10.01	HOSPITAL		10.01
10.02	HOSPITAL		10.02
10.03	HOSPITAL		10.03
10.04	HOSPITAL		10.04
10.05	HOSPITAL		10.05
10.06	HOSPITAL		10.06
10.07	HOSPITAL		10.07
10.08	HOSPITAL		10.08
10.09	HOSPITAL		10.09
10.10	HOSPITAL		10.10
10.11	HOSPITAL		10.11
10.12	HOSPITAL		10.12
10.13	HOSPITAL		10.13
10.14	HOSPITAL		10.14
10.15	HOSPITAL		10.15
10.16	HOSPITAL		10.16
10.17	HOSPITAL		10.17
10.18	HOSPITAL		10.18
10.19	HOSPITAL		10.19

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-1 Date/Time Prepared: 2/27/2017 2:04 pm

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
10.20	HOSPITAL		10.20
10.22	THERAPY PROVIDE		10.22
100.00			100.00

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

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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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2017 2:04 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	1,013	0	1,013	179,000	7	1.00
2.00	59.00	CARDIAC CATHETERIZATION	39,563	0	39,563	179,000	274	2.00
3.00	60.00	LABORATORY	400	0	400	260,300	3	3.00
4.00	69.00	ELECTROCARDIOLOGY	86,053	86,053	0	0	0	4.00
5.00	69.01	CARDIAC REHAB	3,510	0	3,510	271,900	29	5.00
6.00	74.00	RENAL DIALYSIS	1,050	0	1,050	179,000	7	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			131,589	86,053	45,536		320	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	602	30	0	0	0	1.00
2.00	59.00	CARDIAC CATHETERIZATION	23,580	1,179	0	0	0	2.00
3.00	60.00	LABORATORY	375	19	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	69.01	CARDIAC REHAB	3,791	190	0	0	0	5.00
6.00	74.00	RENAL DIALYSIS	602	30	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			28,950	1,448	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	602	411	411		1.00
2.00	59.00	CARDIAC CATHETERIZATION	0	23,580	15,983	15,983		2.00
3.00	60.00	LABORATORY	0	375	25	25		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	86,053		4.00
5.00	69.01	CARDIAC REHAB	0	3,791	0	0		5.00
6.00	74.00	RENAL DIALYSIS	0	602	448	448		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	28,950	16,867	102,920		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 2:04 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	1,023,486	1,023,486				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,611,050		2,611,050			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,822,626	0	0	2,822,626		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,174,569	8,357	65,683	238,320	4,486,929	5.00
7.00	00700	OPERATION OF PLANT	284,527	13,432	0	0	297,959	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,592	0	0	0	79,592	8.00
9.00	00900	HOUSEKEEPING	80,386	5,288	0	0	85,674	9.00
10.00	01000	DIETARY	49,333	0	0	0	49,333	10.00
11.00	01100	CAFETERIA	133,239	0	0	0	133,239	11.00
13.00	01300	NURSING ADMINISTRATION	76,802	0	441	0	77,243	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,466	0	0	0	71,466	14.00
15.00	01500	PHARMACY	62,995	0	0	0	62,995	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	142,822	0	0	0	142,822	16.00
17.00	01700	SOCIAL SERVICE	125,870	0	0	0	125,870	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,713,655	420,341	645,539	1,016,455	6,795,990	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,816,383	136,794	156,023	197,231	3,306,431	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	613,559	0	0	1,857	615,416	54.00
59.00	05900	CARDIAC CATHETERIZATION	5,206,101	309,968	1,271,143	777,932	7,565,144	59.00
60.00	06000	LABORATORY	1,920,844	0	0	0	1,920,844	60.00
64.00	06400	INTRAVENOUS THERAPY	712,488	0	18,899	180,039	911,426	64.00
65.00	06500	RESPIRATORY THERAPY	611,466	0	0	0	611,466	65.00
66.00	06600	PHYSICAL THERAPY	129,315	0	0	0	129,315	66.00
69.00	06900	ELECTROCARDIOLOGY	1,270,310	129,306	419,668	252,283	2,071,567	69.00
69.01	06901	CARDIAC REHAB	642,559	0	33,654	148,882	825,095	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,487,263	0	0	0	1,487,263	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,071,062	0	0	0	8,071,062	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,884,239	0	0	0	1,884,239	73.00
74.00	07400	RENAL DIALYSIS	65,684	0	0	9,398	75,082	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,883,691	1,023,486	2,611,050	2,822,397	41,883,462	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	1,329	0	0	229	1,558	192.00
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	24,929	0	0	0	24,929	194.02
194.03	07953	DEACONESS HOSPITAL	39,877	0	0	0	39,877	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,949,826	1,023,486	2,611,050	2,822,626	41,949,826	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 2:04 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	4,486,929					5.00
7.00	00700	OPERATION OF PLANT	35,687	333,646				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,533	0	89,125			8.00
9.00	00900	HOUSEKEEPING	10,261	1,761	0	97,696		9.00
10.00	01000	DIETARY	5,909	0	0	0	55,242	10.00
11.00	01100	CAFETERIA	15,958	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,251	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,559	0	0	0	0	14.00
15.00	01500	PHARMACY	7,545	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,106	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	15,075	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	813,956	140,008	52,445	41,214	54,237	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	396,011	45,564	1,512	13,412	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,708	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	906,077	103,244	26,125	30,392	1,005	59.00
60.00	06000	LABORATORY	230,059	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	109,161	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	73,235	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	15,488	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	248,112	43,069	9,043	12,678	0	69.00
69.01	06901	CARDIAC REHAB	98,822	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	178,129	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	966,670	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	225,675	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,993	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,478,980	333,646	89,125	97,696	55,242	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	187	0	0	0	0	192.00
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	2,986	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	4,776	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,486,929	333,646	89,125	97,696	55,242	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 2:04 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	149,197					11.00
13.00	01300	NURSING ADMINISTRATION	0	86,494				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	80,025			14.00
15.00	01500	PHARMACY	0	0	194	70,734		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	159,928	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,342	37,912	1,406	0	11,956	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,217	6,509	7,962	0	18,434	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109	0	0	0	9,617	54.00
59.00	05900	CARDIAC CATHETERIZATION	38,661	22,402	399	0	55,056	59.00
60.00	06000	LABORATORY	0	0	0	0	7,486	60.00
64.00	06400	INTRAVENOUS THERAPY	8,494	4,952	292	0	1,364	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	3	0	2,549	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,537	66.00
69.00	06900	ELECTROCARDIOLOGY	14,157	8,192	453	0	19,565	69.00
69.01	06901	CARDIAC REHAB	10,781	6,254	26	0	1,536	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	19,524	0	2,798	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	49,766	0	17,142	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	70,734	10,623	73.00
74.00	07400	RENAL DIALYSIS	436	273	0	0	265	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	149,197	86,494	80,025	70,734	159,928	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
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	149,197	86,494	80,025	70,734	159,928	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 2:04 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	140,945					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	138,387	8,152,853	0	8,152,853		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,807,052	0	3,807,052		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	698,850	0	698,850		54.00
59.00	05900	CARDIAC CATHETERIZATION	2,558	8,751,063	0	8,751,063		59.00
60.00	06000	LABORATORY	0	2,158,389	0	2,158,389		60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,035,689	0	1,035,689		64.00
65.00	06500	RESPIRATORY THERAPY	0	687,253	0	687,253		65.00
66.00	06600	PHYSICAL THERAPY	0	146,340	0	146,340		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,426,836	0	2,426,836		69.00
69.01	06901	CARDIAC REHAB	0	942,514	0	942,514		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,687,714	0	1,687,714		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,104,640	0	9,104,640		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,191,271	0	2,191,271		73.00
74.00	07400	RENAL DIALYSIS	0	85,049	0	85,049		74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	140,945	41,875,513	0	41,875,513		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	1,745	0	1,745		192.00
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0		194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0		194.01
194.02	07952	PUBLIC RELATIONS	0	27,915	0	27,915		194.02
194.03	07953	DEACONESS HOSPITAL	0	44,653	0	44,653		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	140,945	41,949,826	0	41,949,826		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 2:04 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	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	8,357	65,683	74,040	0	5.00
7.00	00700	OPERATION OF PLANT	0	13,432	0	13,432	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,288	0	5,288	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	441	441	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	420,341	645,539	1,065,880	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	136,794	156,023	292,817	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	309,968	1,271,143	1,581,111	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	18,899	18,899	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	129,306	419,668	548,974	0	69.00
69.01	06901	CARDIAC REHAB	0	0	33,654	33,654	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,023,486	2,611,050	3,634,536	0	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
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,023,486	2,611,050	3,634,536	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 2:04 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	74,040					5.00
7.00	00700	OPERATION OF PLANT	589	14,021				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	157	0	157			8.00
9.00	00900	HOUSEKEEPING	169	74	0	5,531		9.00
10.00	01000	DIETARY	97	0	0	0	97	10.00
11.00	01100	CAFETERIA	263	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	153	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	141	0	0	0	0	14.00
15.00	01500	PHARMACY	124	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	282	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	249	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,429	5,883	92	2,333	95	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,534	1,915	3	759	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,216	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	14,949	4,339	46	1,721	2	59.00
60.00	06000	LABORATORY	3,796	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,801	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,208	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	256	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,093	1,810	16	718	0	69.00
69.01	06901	CARDIAC REHAB	1,630	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,939	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,963	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,723	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	148	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	73,909	14,021	157	5,531	97	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	3	0	0	0	0	192.00
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	49	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	79	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	74,040	14,021	157	5,531	97	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 2:04 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	263					11.00
13.00	01300	NURSING ADMINISTRATION	0	594				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	141			14.00
15.00	01500	PHARMACY	0	0	0	124		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	282	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	115	260	3	0	26	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20	45	14	0	41	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	21	54.00
59.00	05900	CARDIAC CATHETERIZATION	68	154	1	0	52	59.00
60.00	06000	LABORATORY	0	0	0	0	16	60.00
64.00	06400	INTRAVENOUS THERAPY	15	34	1	0	3	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	6	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3	66.00
69.00	06900	ELECTROCARDIOLOGY	25	56	1	0	43	69.00
69.01	06901	CARDIAC REHAB	19	43	0	0	3	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	36	0	6	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	85	0	38	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	124	23	73.00
74.00	07400	RENAL DIALYSIS	1	2	0	0	1	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	263	594	141	124	282	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
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	263	594	141	124	282	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 2:04 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	249					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	244	1,088,360	0	1,088,360		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	302,148	0	302,148		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,237	0	1,237		54.00
59.00	05900	CARDIAC CATHETERIZATION	5	1,602,448	0	1,602,448		59.00
60.00	06000	LABORATORY	0	3,812	0	3,812		60.00
64.00	06400	INTRAVENOUS THERAPY	0	20,753	0	20,753		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,214	0	1,214		65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	259		66.00
69.00	06900	ELECTROCARDIOLOGY	0	555,736	0	555,736		69.00
69.01	06901	CARDIAC REHAB	0	35,349	0	35,349		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,981	0	2,981		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,086	0	16,086		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,870	0	3,870		73.00
74.00	07400	RENAL DIALYSIS	0	152	0	152		74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	249	3,634,405	0	3,634,405		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	3	0	3		192.00
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0		194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0		194.01
194.02	07952	PUBLIC RELATIONS	0	49	0	49		194.02
194.03	07953	DEACONESS HOSPITAL	0	79	0	79		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	249	3,634,536	0	3,634,536		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 2:04 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	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	53,032					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,688,029				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,237,332			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	433	42,464	779,926	-4,486,929	37,462,897	5.00
7.00	00700	OPERATION OF PLANT	696	0	0	0	297,959	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	79,592	8.00
9.00	00900	HOUSEKEEPING	274	0	0	0	85,674	9.00
10.00	01000	DIETARY	0	0	0	0	49,333	10.00
11.00	01100	CAFETERIA	0	0	0	0	133,239	11.00
13.00	01300	NURSING ADMINISTRATION	0	285	0	0	77,243	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	71,466	14.00
15.00	01500	PHARMACY	0	0	0	0	62,995	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	142,822	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	125,870	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,780	417,337	3,326,456	0	6,795,990	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,088	100,868	645,458	0	3,306,431	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	6,076	0	615,416	54.00
59.00	05900	CARDIAC CATHETERIZATION	16,061	821,787	2,545,863	0	7,565,144	59.00
60.00	06000	LABORATORY	0	0	0	0	1,920,844	60.00
64.00	06400	INTRAVENOUS THERAPY	0	12,218	589,195	0	911,426	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	611,466	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	129,315	66.00
69.00	06900	ELECTROCARDIOLOGY	6,700	271,313	825,621	0	2,071,567	69.00
69.01	06901	CARDIAC REHAB	0	21,757	487,232	0	825,095	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,487,263	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,071,062	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,884,239	73.00
74.00	07400	RENAL DIALYSIS	0	0	30,756	0	75,082	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,032	1,688,029	9,236,583	-4,486,929	37,396,533	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	749	0	1,558	192.00
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	24,929	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	39,877	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,023,486	2,611,050	2,822,626		4,486,929	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.299404	1.546804	0.305567		0.119770	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		74,040	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.001976	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 2:04 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S - A)	
			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	51,903					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	186,552				8.00
9.00	00900	HOUSEKEEPING	274	0	51,629			9.00
10.00	01000	DIETARY	0	0	0	21,387		10.00
11.00	01100	CAFETERIA	0	0	0	0	1,370	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,780	109,775	21,780	20,998	600	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,088	3,165	7,088	0	103	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	1	54.00
59.00	05900	CARDIAC CATHETERIZATION	16,061	54,683	16,061	389	355	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	78	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	6,700	18,929	6,700	0	130	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	99	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	4	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,903	186,552	51,629	21,387	1,370	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
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	333,646	89,125	97,696	55,242	149,197	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.428260	0.477749	1.892270	2.582971	108.902920	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,021	157	5,531	97	263	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.270139	0.000842	0.107130	0.004535	0.191971	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 2:04 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	284,765					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,566,111				14.00
15.00	01500	PHARMACY	0	35,223	1,884,239			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	176,220,509		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	7,054	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	124,815	255,930	0	13,167,815	6,926	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,429	1,449,143	0	20,301,419	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,591,509	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	73,756	72,627	0	60,724,050	128	59.00
60.00	06000	LABORATORY	0	0	0	8,244,076	0	60.00
64.00	06400	INTRAVENOUS THERAPY	16,305	53,138	0	1,501,789	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	603	0	2,807,165	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,693,053	0	66.00
69.00	06900	ELECTROCARDIOLOGY	26,972	82,445	0	21,547,205	0	69.00
69.01	06901	CARDIAC REHAB	20,590	4,794	0	1,691,493	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,553,767	0	3,081,102	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,058,441	0	18,878,389	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,884,239	11,699,711	0	73.00
74.00	07400	RENAL DIALYSIS	898	0	0	291,733	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	284,765	14,566,111	1,884,239	176,220,509	7,054	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
194.00	07954	MISC NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	86,494	80,025	70,734	159,928	140,945	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.303738	0.005494	0.037540	0.000908	19.980862	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	594	141	124	282	249	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002086	0.000010	0.000066	0.000002	0.035299	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 2:04 pm

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		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	8,152,853		8,152,853	0	8,152,853	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,807,052		3,807,052	0	3,807,052	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	698,850		698,850	0	698,850	54.00
59.00	05900	CARDIAC CATHETERIZATION	8,751,063		8,751,063	15,983	8,767,046	59.00
60.00	06000	LABORATORY	2,158,389		2,158,389	25	2,158,414	60.00
64.00	06400	INTRAVENOUS THERAPY	1,035,689		1,035,689	0	1,035,689	64.00
65.00	06500	RESPIRATORY THERAPY	687,253	0	687,253	0	687,253	65.00
66.00	06600	PHYSICAL THERAPY	146,340	0	146,340	0	146,340	66.00
69.00	06900	ELECTROCARDIOLOGY	2,426,836		2,426,836	0	2,426,836	69.00
69.01	06901	CARDIAC REHAB	942,514		942,514	0	942,514	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,687,714		1,687,714	0	1,687,714	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,104,640		9,104,640	0	9,104,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,191,271		2,191,271	0	2,191,271	73.00
74.00	07400	RENAL DIALYSIS	85,049		85,049	448	85,497	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	845,187		845,187		845,187	92.00
200.00		Subtotal (see instructions)	42,720,700	0	42,720,700	16,456	42,737,156	200.00
201.00		Less Observation Beds	845,187		845,187		845,187	201.00
202.00		Total (see instructions)	41,875,513	0	41,875,513	16,456	41,891,969	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 2:04 pm

Title XVIII | Hospital | PPS

		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	12,152,308		12,152,308			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,183,988	1,117,431	20,301,419	0.187526	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,849,473	6,742,036	10,591,509	0.065982	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	22,411,947	38,312,103	60,724,050	0.144112	0.000000	59.00
60.00	06000	LABORATORY	7,349,091	894,985	8,244,076	0.261811	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	1,479,861	21,928	1,501,789	0.689637	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,776,555	30,610	2,807,165	0.244821	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,661,119	31,934	1,693,053	0.086436	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	11,190,811	10,356,394	21,547,205	0.112629	0.000000	69.00
69.01	06901	CARDIAC REHAB	477	1,691,016	1,691,493	0.557208	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,411,796	669,306	3,081,102	0.547763	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,150,660	12,727,730	18,878,390	0.482278	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,102,132	2,597,580	11,699,712	0.187293	0.000000	73.00
74.00	07400	RENAL DIALYSIS	269,758	21,975	291,733	0.291530	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	230,102	785,405	1,015,507	0.832281	0.000000	92.00
200.00		Subtotal (see instructions)	100,220,078	76,000,433	176,220,511			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	100,220,078	76,000,433	176,220,511			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 2:04 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.187526	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065982	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.144375	59.00
60.00	06000	LABORATORY	0.261814	60.00
64.00	06400	INTRAVENOUS THERAPY	0.689637	64.00
65.00	06500	RESPIRATORY THERAPY	0.244821	65.00
66.00	06600	PHYSICAL THERAPY	0.086436	66.00
69.00	06900	ELECTROCARDIOLOGY	0.112629	69.00
69.01	06901	CARDIAC REHAB	0.557208	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.547763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.482278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187293	73.00
74.00	07400	RENAL DIALYSIS	0.293066	74.00
		OUTPATIENT SERVICE COST CENTERS		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.832281	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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,152,853		8,152,853	0	8,152,853	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,807,052		3,807,052	0	3,807,052	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	698,850		698,850	0	698,850	54.00
59.00	05900	CARDIAC CATHETERIZATION	8,751,063		8,751,063	15,983	8,767,046	59.00
60.00	06000	LABORATORY	2,158,389		2,158,389	25	2,158,414	60.00
64.00	06400	INTRAVENOUS THERAPY	1,035,689		1,035,689	0	1,035,689	64.00
65.00	06500	RESPIRATORY THERAPY	687,253	0	687,253	0	687,253	65.00
66.00	06600	PHYSICAL THERAPY	146,340	0	146,340	0	146,340	66.00
69.00	06900	ELECTROCARDIOLOGY	2,426,836		2,426,836	0	2,426,836	69.00
69.01	06901	CARDIAC REHAB	942,514		942,514	0	942,514	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,687,714		1,687,714	0	1,687,714	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,104,640		9,104,640	0	9,104,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,191,271		2,191,271	0	2,191,271	73.00
74.00	07400	RENAL DIALYSIS	85,049		85,049	448	85,497	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	845,187		845,187		845,187	92.00
200.00		Subtotal (see instructions)	42,720,700	0	42,720,700	16,456	42,737,156	200.00
201.00		Less Observation Beds	845,187		845,187		845,187	201.00
202.00		Total (see instructions)	41,875,513	0	41,875,513	16,456	41,891,969	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 2:04 pm

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		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	12,152,308		12,152,308			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,183,988	1,117,431	20,301,419	0.187526	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,849,473	6,742,036	10,591,509	0.065982	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	22,411,947	38,312,103	60,724,050	0.144112	0.000000	59.00
60.00	06000	LABORATORY	7,349,091	894,985	8,244,076	0.261811	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	1,479,861	21,928	1,501,789	0.689637	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,776,555	30,610	2,807,165	0.244821	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,661,119	31,934	1,693,053	0.086436	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	11,190,811	10,356,394	21,547,205	0.112629	0.000000	69.00
69.01	06901	CARDIAC REHAB	477	1,691,016	1,691,493	0.557208	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,411,796	669,306	3,081,102	0.547763	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,150,660	12,727,730	18,878,390	0.482278	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,102,132	2,597,580	11,699,712	0.187293	0.000000	73.00
74.00	07400	RENAL DIALYSIS	269,758	21,975	291,733	0.291530	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	230,102	785,405	1,015,507	0.832281	0.000000	92.00
200.00		Subtotal (see instructions)	100,220,078	76,000,433	176,220,511			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	100,220,078	76,000,433	176,220,511			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.187526		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065982		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.144375		59.00
60.00	06000	LABORATORY	0.261814		60.00
64.00	06400	INTRAVENOUS THERAPY	0.689637		64.00
65.00	06500	RESPIRATORY THERAPY	0.244821		65.00
66.00	06600	PHYSICAL THERAPY	0.086436		66.00
69.00	06900	ELECTROCARDIOLOGY	0.112629		69.00
69.01	06901	CARDIAC REHAB	0.557208		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.547763		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.482278		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187293		73.00
74.00	07400	RENAL DIALYSIS	0.293066		74.00
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.832281		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part II Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,807,052	302,148	3,504,904	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	698,850	1,237	697,613	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	8,751,063	1,602,448	7,148,615	0	0	59.00
60.00	06000	LABORATORY	2,158,389	3,812	2,154,577	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,035,689	20,753	1,014,936	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	687,253	1,214	686,039	0	0	65.00
66.00	06600	PHYSICAL THERAPY	146,340	259	146,081	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,426,836	555,736	1,871,100	0	0	69.00
69.01	06901	CARDIAC REHAB	942,514	35,349	907,165	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,687,714	2,981	1,684,733	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,104,640	16,086	9,088,554	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,191,271	3,870	2,187,401	0	0	73.00
74.00	07400	RENAL DIALYSIS	85,049	152	84,897	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	845,187	112,827	732,360	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	34,567,847	2,658,872	31,908,975	0	0	200.00
201.00		Less Observation Beds	845,187	112,827	732,360	0	0	201.00
202.00		Total (line 200 minus line 201)	33,722,660	2,546,045	31,176,615	0	0	202.00

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

Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part II | Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,807,052	20,301,419	0.187526		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	698,850	10,591,509	0.065982		54.00
59.00	05900	CARDIAC CATHETERIZATION	8,751,063	60,724,050	0.144112		59.00
60.00	06000	LABORATORY	2,158,389	8,244,076	0.261811		60.00
64.00	06400	INTRAVENOUS THERAPY	1,035,689	1,501,789	0.689637		64.00
65.00	06500	RESPIRATORY THERAPY	687,253	2,807,165	0.244821		65.00
66.00	06600	PHYSICAL THERAPY	146,340	1,693,053	0.086436		66.00
69.00	06900	ELECTROCARDIOLOGY	2,426,836	21,547,205	0.112629		69.00
69.01	06901	CARDIAC REHAB	942,514	1,691,493	0.557208		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,687,714	3,081,102	0.547763		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,104,640	18,878,390	0.482278		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,191,271	11,699,712	0.187293		73.00
74.00	07400	RENAL DIALYSIS	85,049	291,733	0.291530		74.00
		OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	845,187	1,015,507	0.832281		92.00
200.00		Subtotal (sum of lines 50 thru 199)	34,567,847	164,068,203			200.00
201.00		Less Observation Beds	845,187	0			201.00
202.00		Total (line 200 minus line 201)	33,722,660	164,068,203			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 2/27/2017 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,088,360	0	1,088,360	6,926	157.14	30.00
200.00	Total (lines 30-199)	1,088,360		1,088,360	6,926		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	3,282	515,733	30.00
200.00	Total (lines 30-199)	3,282	515,733	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/27/2017 2:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	302,148	20,301,419	0.014883	8,748,996	130,211	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,237	10,591,509	0.000117	1,412,558	165	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,602,448	60,724,050	0.026389	11,355,412	299,658	59.00
60.00	06000	LABORATORY	3,812	8,244,076	0.000462	3,658,701	1,690	60.00
64.00	06400	INTRAVENOUS THERAPY	20,753	1,501,789	0.013819	51,925	718	64.00
65.00	06500	RESPIRATORY THERAPY	1,214	2,807,165	0.000432	1,274,640	551	65.00
66.00	06600	PHYSICAL THERAPY	259	1,693,053	0.000153	1,052,118	161	66.00
69.00	06900	ELECTROCARDIOLOGY	555,736	21,547,205	0.025792	1,241,708	32,026	69.00
69.01	06901	CARDIAC REHAB	35,349	1,691,493	0.020898	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,981	3,081,102	0.000968	970,237	939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,086	18,878,390	0.000852	3,484,511	2,969	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,870	11,699,712	0.000331	4,170,077	1,380	73.00
74.00	07400	RENAL DIALYSIS	152	291,733	0.000521	83,180	43	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	112,827	1,015,507	0.111104	146,165	16,240	92.00
200.00		Total (lines 50-199)	2,658,872	164,068,203		37,650,228	486,751	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/27/2017 2:04 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,926	0.00	3,282	0		30.00
200.00		Total (lines 30-199)	6,926		3,282	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 2:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 2:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	20,301,419	0.000000	0.000000	8,748,996	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,591,509	0.000000	0.000000	1,412,558	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	60,724,050	0.000000	0.000000	11,355,412	59.00
60.00	06000	LABORATORY	0	8,244,076	0.000000	0.000000	3,658,701	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,501,789	0.000000	0.000000	51,925	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,807,165	0.000000	0.000000	1,274,640	65.00
66.00	06600	PHYSICAL THERAPY	0	1,693,053	0.000000	0.000000	1,052,118	66.00
69.00	06900	ELECTROCARDIOLOGY	0	21,547,205	0.000000	0.000000	1,241,708	69.00
69.01	06901	CARDIAC REHAB	0	1,691,493	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,081,102	0.000000	0.000000	970,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,878,390	0.000000	0.000000	3,484,511	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,699,712	0.000000	0.000000	4,170,077	73.00
74.00	07400	RENAL DIALYSIS	0	291,733	0.000000	0.000000	83,180	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,015,507	0.000000	0.000000	146,165	92.00
200.00		Total (lines 50-199)	0	164,068,203			37,650,228	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 2:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	436,974	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	977,088	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,941,550	0		59.00
60.00	06000	LABORATORY	0	345,549	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	8,822	0		65.00
66.00	06600	PHYSICAL THERAPY	0	6,768	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,743,494	0		69.00
69.01	06901	CARDIAC REHAB	0	727,749	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	198,572	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,300,209	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	958,939	0		73.00
74.00	07400	RENAL DIALYSIS	0	3,640	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	43,744	0		92.00
200.00		Total (lines 50-199)	0	28,693,098	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 2:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.187526	436,974	0	0	81,944	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065982	977,088	0	0	64,470	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.144112	16,941,550	0	13,259	2,441,481	59.00
60.00	06000	LABORATORY	0.261811	345,549	0	0	90,469	60.00
64.00	06400	INTRAVENOUS THERAPY	0.689637	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.244821	8,822	0	0	2,160	65.00
66.00	06600	PHYSICAL THERAPY	0.086436	6,768	0	0	585	66.00
69.00	06900	ELECTROCARDIOLOGY	0.112629	1,743,494	0	491	196,368	69.00
69.01	06901	CARDIAC REHAB	0.557208	727,749	0	0	405,508	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.547763	198,572	0	0	108,770	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.482278	6,300,209	0	0	3,038,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187293	958,939	0	51,545	179,603	73.00
74.00	07400	RENAL DIALYSIS	0.291530	3,640	0	0	1,061	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.832281	43,744	0	0	36,407	92.00
200.00		Subtotal (see instructions)		28,693,098	0	65,295	6,647,278	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		28,693,098	0	65,295	6,647,278	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 2:04 pm

Title XVIII | Hospital | PPS

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,911		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	55		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
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	9,654		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	11,620		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	11,620		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,088,360	0	1,088,360	6,926	157.14	30.00
200.00	Total (lines 30-199)	1,088,360		1,088,360	6,926		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	97	15,243	30.00
200.00	Total (lines 30-199)	97	15,243	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	302,148	20,301,419	0.014883	1,128,914	16,802	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,237	10,591,509	0.000117	88,861	10	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,602,448	60,724,050	0.026389	1,000,769	26,409	59.00
60.00	06000	LABORATORY	3,812	8,244,076	0.000462	337,577	156	60.00
64.00	06400	INTRAVENOUS THERAPY	20,753	1,501,789	0.013819	8,223	114	64.00
65.00	06500	RESPIRATORY THERAPY	1,214	2,807,165	0.000432	105,769	46	65.00
66.00	06600	PHYSICAL THERAPY	259	1,693,053	0.000153	45,217	7	66.00
69.00	06900	ELECTROCARDIOLOGY	555,736	21,547,205	0.025792	122,403	3,157	69.00
69.01	06901	CARDIAC REHAB	35,349	1,691,493	0.020898	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,981	3,081,102	0.000968	25,758	25	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,086	18,878,390	0.000852	192,327	164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,870	11,699,712	0.000331	442,940	147	73.00
74.00	07400	RENAL DIALYSIS	152	291,733	0.000521	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	112,827	1,015,507	0.111104	11,224	1,247	92.00
200.00		Total (lines 50-199)	2,658,872	164,068,203		3,509,982	48,284	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,926	0.00	97	0		30.00
200.00		Total (lines 30-199)	6,926		97	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 2:04 pm

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		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	20,301,419	0.000000	0.000000	1,128,914	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,591,509	0.000000	0.000000	88,861	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	60,724,050	0.000000	0.000000	1,000,769	59.00
60.00	06000	LABORATORY	0	8,244,076	0.000000	0.000000	337,577	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,501,789	0.000000	0.000000	8,223	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,807,165	0.000000	0.000000	105,769	65.00
66.00	06600	PHYSICAL THERAPY	0	1,693,053	0.000000	0.000000	45,217	66.00
69.00	06900	ELECTROCARDIOLOGY	0	21,547,205	0.000000	0.000000	122,403	69.00
69.01	06901	CARDIAC REHAB	0	1,691,493	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,081,102	0.000000	0.000000	25,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,878,390	0.000000	0.000000	192,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,699,712	0.000000	0.000000	442,940	73.00
74.00	07400	RENAL DIALYSIS	0	291,733	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,015,507	0.000000	0.000000	11,224	92.00
200.00		Total (lines 50-199)	0	164,068,203			3,509,982	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 2:04 pm

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.187526	0	0	56,295	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065982	0	0	146,650	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.144112	0	0	2,579,739	0	59.00
60.00	06000	LABORATORY	0.261811	0	0	80,298	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.689637	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.244821	0	0	3,369	0	65.00
66.00	06600	PHYSICAL THERAPY	0.086436	0	0	4,832	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.112629	0	0	448,068	0	69.00
69.01	06901	CARDIAC REHAB	0.557208	0	0	63,568	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.547763	0	0	54,548	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.482278	0	0	760,065	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187293	0	0	182,831	0	73.00
74.00	07400	RENAL DIALYSIS	0.291530	0	0	1,998	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.832281	0	0	107,550	0	92.00
200.00		Subtotal (see instructions)		0	0	4,489,811	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	4,489,811	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

		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	10,557		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,676		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	371,771		59.00
60.00	06000	LABORATORY	0	21,023		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	825		65.00
66.00	06600	PHYSICAL THERAPY	0	418		66.00
69.00	06900	ELECTROCARDIOLOGY	0	50,465		69.00
69.01	06901	CARDIAC REHAB	0	35,421		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,879		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	366,563		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,243		73.00
74.00	07400	RENAL DIALYSIS	0	582		74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	89,512		92.00
200.00		Subtotal (see instructions)	0	1,020,935		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,020,935		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 2:04 pm

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	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)	6,926	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,926	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)	6,208	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,282	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,152,853	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,152,853	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)	8,152,853	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)	1,177.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,863,373	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)	3,863,373	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 2:04 pm

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,048,881	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	11,912,254	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)	515,733	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	486,751	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,002,484	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	10,909,770	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)	718	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,177.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	845,187	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 2:04 pm

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,088,360	8,152,853	0.133494	845,187	112,827	90.00
91.00	Nursing School cost	0	8,152,853	0.000000	845,187	0	91.00
92.00	Allied health cost	0	8,152,853	0.000000	845,187	0	92.00
93.00	All other Medical Education	0	8,152,853	0.000000	845,187	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 2:04 pm

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	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)	6,926	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,926	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)	6,208	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	97	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,152,853	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,152,853	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)	8,152,853	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)	1,177.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	114,183	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)	114,183	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 2:04 pm

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	698,857	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	813,040	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)	15,243	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	48,284	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	63,527	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	749,513	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)	718	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,177.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	845,187	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,088,360	8,152,853	0.133494	845,187	112,827	90.00
91.00	Nursing School cost	0	8,152,853	0.000000	845,187	0	91.00
92.00	Allied health cost	0	8,152,853	0.000000	845,187	0	92.00
93.00	All other Medical Education	0	8,152,853	0.000000	845,187	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 2:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		6,122,079		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.187526	8,748,996	1,640,664	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065982	1,412,558	93,203	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.144375	11,355,412	1,639,438	59.00
60.00	06000	LABORATORY	0.261814	3,658,701	957,899	60.00
64.00	06400	INTRAVENOUS THERAPY	0.689637	51,925	35,809	64.00
65.00	06500	RESPIRATORY THERAPY	0.244821	1,274,640	312,059	65.00
66.00	06600	PHYSICAL THERAPY	0.086436	1,052,118	90,941	66.00
69.00	06900	ELECTROCARDIOLOGY	0.112629	1,241,708	139,852	69.00
69.01	06901	CARDIAC REHAB	0.557208	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.547763	970,237	531,460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.482278	3,484,511	1,680,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187293	4,170,077	781,026	73.00
74.00	07400	RENAL DIALYSIS	0.293066	83,180	24,377	74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.832281	146,165	121,650	92.00
200.00		Total (sum of lines 50-94 and 96-98)		37,650,228	8,048,881	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)		37,650,228		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 2:04 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		542,954		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.187526	1,128,914	211,701	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065982	88,861	5,863	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.144375	1,000,769	144,486	59.00
60.00	06000	LABORATORY	0.261814	337,577	88,382	60.00
64.00	06400	INTRAVENOUS THERAPY	0.689637	8,223	5,671	64.00
65.00	06500	RESPIRATORY THERAPY	0.244821	105,769	25,894	65.00
66.00	06600	PHYSICAL THERAPY	0.086436	45,217	3,908	66.00
69.00	06900	ELECTROCARDIOLOGY	0.112629	122,403	13,786	69.00
69.01	06901	CARDIAC REHAB	0.557208	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.547763	25,758	14,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.482278	192,327	92,755	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187293	442,940	82,960	73.00
74.00	07400	RENAL DIALYSIS	0.293066	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.832281	11,224	9,342	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,509,982	698,857	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,509,982		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/27/2017 2:04 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,443,696	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	127,974	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	22.04	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/27/2017 2:04 pm
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000010719	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	10,571,670		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		10,571,670	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		845,724	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment			54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		11,417,394	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,417,394	61.00
62.00	Deductibles billed to program beneficiaries		763,532	62.00
63.00	Coinsurance billed to program beneficiaries		6,342	63.00
64.00	Allowable bad debts (see instructions)		43,311	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		28,152	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		27,692	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,675,672	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		3,132	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		95,485	70.93
70.94	HRR adjustment amount (see instructions)		-40,730	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/27/2017 2:04 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,727,295	71.00
71.01	Sequestration adjustment (see instructions)		214,546	71.01
72.00	Interim payments		10,485,160	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		27,589	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		20,887	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/27/2017 2:04 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,443,696	0		10,443,696	10,443,696	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	127,974	0	0	127,974	127,974	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	10,571,670	0	0	10,571,670	10,571,670	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,571,670	0	0	10,571,670	10,571,670	15.00
16.00	Payment for inpatient program capital	50.00	845,724	0	0	845,724	845,724	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	3,132	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/27/2017 2:04 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	0	11,417,394	11,417,394	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	830,461	0	0	830,461	830,461	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	15,263	0	0	15,263	15,263	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	845,724	0	0	845,724	845,724	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.107679		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				1,229,414	1,229,414	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/27/2017 2:04 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,443,696		10,443,696	10,443,696	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	127,974	0	127,974	127,974	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	10,571,670	0	10,571,670	10,571,670	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,571,670	0	10,571,670	10,571,670	15.00
16.00	Payment for inpatient program capital	50.00	845,724	0	845,724	845,724	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	3,132	0	3,132	3,132	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	11,420,526	11,420,526	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/27/2017 2:04 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	830,461	0	830,461	830,461	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	15,263	0	15,263	15,263	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	845,724	0	845,724	845,724	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	95,485	0	95,485	95,485	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-40,730	0	-40,730	-40,730	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/27/2017 2:04 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	11,620	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,647,278	2.00
3.00	PPS payments	7,941,142	3.00
4.00	Outlier payment (see instructions)	44,135	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)	11,620	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	65,295	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)	65,295	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)	65,295	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	53,675	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)	11,620	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)	7,985,277	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	978,975	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)	7,017,922	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)	7,017,922	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	7,017,922	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)	62,517	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	40,636	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	51,801	36.00
37.00	Subtotal (see instructions)	7,058,558	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)	7,058,558	40.00
40.01	Sequestration adjustment (see instructions)	141,171	40.01
41.00	Interim payments	6,871,122	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	46,265	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: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 2/27/2017 2:04 pm

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		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		10,485,160		6,871,122	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)		10,485,160		6,871,122	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		27,589		46,265	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,512,749		6,917,387	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: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 2/27/2017 2:04 pm
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		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	1,590	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,282	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	865	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	6,208	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	176,220,511	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,217,147	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/27/2017 2:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,749,249	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,752,216	0	0	0	6.00
7.00	Inventory	1,481,222	0	0	0	7.00
8.00	Prepaid expenses	193,999	0	0	0	8.00
9.00	Other current assets	120,627	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)	9,792,881	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	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	14,633,894	0	0	0	19.00
20.00	Accumulated depreciation	-7,096,250	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	7,537,644	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	6,926,347	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,926,347	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,256,872	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,643,955	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,019,612	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	904,873	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,614,447	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,182,887	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,696,376	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)	1,696,376	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,879,263	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	16,377,609				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)	16,377,609	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,256,872	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/27/2017 2:04 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		15,494,369		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,037,529				2.00
3.00	Total (sum of line 1 and line 2)		29,531,898		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		29,531,898		0		11.00
12.00	DISTRIBUTIONS	13,154,291		0		0	12.00
13.00	ROUNDING	-2		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		13,154,289		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,377,609		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	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	DISTRIBUTIONS		0		12.00
13.00	ROUNDING		0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0175 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/27/2017 2:04 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,382,410		12,382,410	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)	12,382,410		12,382,410	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)	12,382,410		12,382,410	17.00
18.00	Ancillary services	78,759,585	66,245,142	145,004,727	18.00
19.00	Outpatient services	0	785,405	785,405	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	91,141,995	67,030,547	158,172,542	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		46,116,417		29.00
30.00	ROUNGING	1			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)		1		36.00
37.00	GROSS UP FOR CREDITS FOR SERVICES TO	3,148,529			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)		3,148,529		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		42,967,889		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet G-3 Date/Time Prepared: 2/27/2017 2:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	158,172,542	1.00
2.00	Less contractual allowances and discounts on patients' accounts	101,285,814	2.00
3.00	Net patient revenues (line 1 minus line 2)	56,886,728	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,967,889	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,918,839	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	15	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	118,675	24.00
25.00	Total other income (sum of lines 6-24)	118,690	25.00
26.00	Total (line 5 plus line 25)	14,037,529	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	14,037,529	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0175	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prepared: 2/27/2017 2:04 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		830,461	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		15,263	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		16.96	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		845,724	12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00