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: 15-1308	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/20/2017 6:20 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/20/2017 Time: 6:20 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT MERCY HOSPITAL (15-1308) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	354,417	-184,654	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	65,937	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	420,354	-184,654	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: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 6:09 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13311 SOUTH A ST.	PO Box:			1.00
2.00	City: ELWOOD	State: IN	Zip Code: 46036-	County: MADISON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT MERCY HOSPITAL	151308	26900	1	07/01/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BED - SNF	15Z308	26900		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 6:09 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2017 6:09 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 6:09 pm

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	42,792	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 6:09 pm

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1308	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 6:09 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2017 6:09 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/02/2017	Y	10/02/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/20/2017 6:09 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1308	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/20/2017 6:09 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.	MANAGER OF REIMBURSEMENT		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: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2017 6:09 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	25,392.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	25,392.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	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)		25	9,125	25,392.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2017 6:09 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)	510	23	1,058			1.00
2.00	HMO and other (see instructions)	180	124				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	103	0	126			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	34			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	613	23	1,218			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			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)	613	23	1,218	0.00	127.98	14.00
15.00	CAH visits	10,503	411	34,500			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	127.98	27.00
28.00	Observation Bed Days		0	357			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: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2017 6:09 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	144	12	317	1.00
2.00	HMO and other (see instructions)			53	33		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	144	12	317	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/20/2017 6:09 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)	0.322889	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	986,773	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	15,726,328	6.00
7.00	Medicaid cost (line 1 times line 6)	5,077,858	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)	4,091,085	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,091,085	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,508,899	934,539	4,443,438	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,132,985	934,539	2,067,524	21.00
22.00	Payments received from patients for amounts previously written off as charity care	69,104	60,328	129,432	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,063,881	874,211	1,938,092	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,578,842	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	647,681	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	996,431	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	582,411	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	536,804	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,474,896	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,565,981	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/20/2017 6:09 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	NEW CAP REL COSTS-BLDG & FIXT		912,154	912,154	-5,362	906,792	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		579,063	579,063	0	579,063	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	262,633	2,199,696	2,462,329	0	2,462,329	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,394,072	2,344,354	3,738,426	-199,694	3,538,732	5.00
7.00	00700	OPERATION OF PLANT	152,063	2,186,682	2,338,745	0	2,338,745	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	33,223	33,223	8.00
9.00	00900	HOUSEKEEPING	0	544,594	544,594	-33,223	511,371	9.00
10.00	01000	DIETARY	0	472,206	472,206	-302,300	169,906	10.00
11.00	01100	CAFETERIA	0	0	0	302,300	302,300	11.00
13.00	01300	NURSING ADMINISTRATION	199,393	10,945	210,338	0	210,338	13.00
15.00	01500	PHARMACY	382,224	3,215,412	3,597,636	-535	3,597,101	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	269,690	101,849	371,539	0	371,539	16.00
17.00	01700	SOCIAL SERVICE	185,102	44,537	229,639	0	229,639	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	915,071	434,437	1,349,508	-538	1,348,970	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	406,208	240,923	647,131	-38,428	608,703	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,000,336	82,708	1,083,044	-491	1,082,553	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,033,177	1,033,177	-80	1,033,097	60.00
65.00	06500	RESPIRATORY THERAPY	483,608	54,595	538,203	-97	538,106	65.00
66.00	06600	PHYSICAL THERAPY	441,010	34,090	475,100	0	475,100	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,825	322	52,147	0	52,147	67.00
68.00	06800	SPEECH PATHOLOGY	43,933	5,012	48,945	0	48,945	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,910	17,910	63,794	81,704	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	98,951	98,951	0	98,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	28,209	1,324	29,533	0	29,533	76.00
76.01	03480	ONCOLOGY	158,504	19,127	177,631	-15	177,616	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	298,657	43,441	342,098	-14,038	328,060	90.00
91.00	09100	EMERGENCY	1,022,908	1,011,120	2,034,028	-9,572	2,024,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,695,446	15,688,629	23,384,075	-205,056	23,179,019	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	07950	MARKETING	0	0	0	205,056	205,056	194.00
194.01	07951	FOUNDATION	0	344	344	0	344	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	7,695,446	15,688,973	23,384,419	0	23,384,419	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/20/2017 6:09 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-383,127	523,665		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	579,063		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	576,148	3,038,477		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	407,128	3,945,860		5.00
7.00	00700	OPERATION OF PLANT	-3,356	2,335,389		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,223		8.00
9.00	00900	HOUSEKEEPING	0	511,371		9.00
10.00	01000	DIETARY	-63,259	106,647		10.00
11.00	01100	CAFETERIA	0	302,300		11.00
13.00	01300	NURSING ADMINISTRATION	0	210,338		13.00
15.00	01500	PHARMACY	-3,264	3,593,837		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,859	363,680		16.00
17.00	01700	SOCIAL SERVICE	0	229,639		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-249,241	1,099,729		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	608,703		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-460	1,082,093		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	-2,000	1,031,097		60.00
65.00	06500	RESPIRATORY THERAPY	0	538,106		65.00
66.00	06600	PHYSICAL THERAPY	0	475,100		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	52,147		67.00
68.00	06800	SPEECH PATHOLOGY	0	48,945		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	81,704		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	98,951		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03610	SLEEP LAB	0	29,533		76.00
76.01	03480	ONCOLOGY	0	177,616		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	328,060		90.00
91.00	09100	EMERGENCY	-150,000	1,874,456		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	120,710	23,299,729		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MARKETING	123,751	328,807		194.00
194.01	07951	FOUNDATION	0	344		194.01
194.02	07952	CLINIC	0	0		194.02
194.03	07953	VACANT	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	244,461	23,628,880		200.00

RECLASSIFICATIONS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/20/2017 6:09 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	0	302,300	1.00
	TOTALS		0	302,300	
	B - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	33,223	1.00
	TOTALS		0	33,223	
	C - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,362	1.00
	TOTALS		0	5,362	
	D - BILLABLE MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	63,794	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
	TOTALS		0	63,794	
	E - MARKETING				
1.00	MARKETING	194.00	0	205,056	1.00
	TOTALS		0	205,056	
500.00	Grand Total: Increases		0	609,735	500.00

RECLASSIFICATIONS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/20/2017 6:09 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	302,300	0		1.00
	TOTALS		0	302,300			
	B - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	33,223	0		1.00
	TOTALS		0	33,223			
	C - INTEREST						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	5,362	9		1.00
	TOTALS		0	5,362			
	D - BILLABLE MED SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	538	0		1.00
2.00	OPERATING ROOM	50.00	0	38,428	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	491	0		3.00
4.00	LABORATORY	60.00	0	80	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	97	0		5.00
6.00	PHARMACY	15.00	0	535	0		6.00
7.00	ONCOLOGY	76.01	0	15	0		7.00
8.00	CLINIC	90.00	0	14,038	0		8.00
9.00	EMERGENCY	91.00	0	9,572	0		9.00
	TOTALS		0	63,794			
	E - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	205,056	0		1.00
	TOTALS		0	205,056			
500.00	Grand Total: Decreases		0	609,735			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2017 6:09 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	457,300	0	0	0	0	1.00
2.00	Land Improvements	528,489	0	0	0	0	2.00
3.00	Buildings and Fixtures	27,795,205	1,180,583	0	1,180,583	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	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,780,994	1,180,583	0	1,180,583	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,780,994	1,180,583	0	1,180,583	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	457,300	0	1.00
2.00	Land Improvements	528,489	0	2.00
3.00	Buildings and Fixtures	28,975,788	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,961,577	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	29,961,577	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II Date/Time Prepared: 11/20/2017 6:09 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	NEW CAP REL COSTS-BLDG & FIXT	912,154	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	579,063	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,491,217	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	NEW CAP REL COSTS-BLDG & FIXT	0	912,154	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	579,063	2.00
3.00	Total (sum of lines 1-2)	0	1,491,217	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/20/2017 6:09 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	28,975,788	0	28,975,788	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	28,975,788	0	28,975,788	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	523,665	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	579,063	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,102,728	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	523,665	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	579,063	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,102,728	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/20/2017 6:09 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-381,086	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-5,333	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,521	ADMINISTRATIVE & GENERAL	5.00	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	-401,043			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,652,050			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-63,259	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-3,264	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,859	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/20/2017 6:09 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	LAB REVENUE	B	-2,000	LABORATORY	60.00	0	33.00
34.00	ADMIN REVENUE	B	-47,806	ADMINISTRATIVE & GENERAL	5.00	0	34.00
36.00	LOBBYING	A	-831	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	INCENTIVE ADJUSTMENT	A	18,470	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
39.00	PHYSICIAN SUPPORT SERVICES	A	-8	ADULTS & PEDIATRICS	30.00	0	39.00
40.00	MARKETING AND COMMUNITY RELATIONS	A	-213	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	MARKETING AND COMMUNITY RELATIONS	A	-3,170	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	PROVIDER TAX	A	-483,292	ADMINISTRATIVE & GENERAL	5.00	0	42.00
42.05	MEDICAL AFFAIRS ADMIN	A	-18,784	ADMINISTRATIVE & GENERAL	5.00	0	42.05
42.06	GIFTS/DONATIONS EXPENSE	A	-590	ADMINISTRATIVE & GENERAL	5.00	0	42.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		244,461				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: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/20/2017 6:09 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	0	89,966	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,151,293	1,175,459	2.00
3.00	194.00	MARKETING	HOME OFFICE	123,751	0	3.00
3.01	0.00			0	0	3.01
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST. VINCENT HEALTH - CHG	339,645	339,645	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH - CHG	1,252,758	1,252,758	4.01
4.02	9.00	HOUSEKEEPING	ST. VINCENT HEALTH - CHG	-29,011	-29,011	4.02
4.03	10.00	DIETARY	ST. VINCENT HEALTH - CHG	-41	-41	4.03
4.04	13.00	NURSING ADMINISTRATION	ST. VINCENT HEALTH - CHG	18,567	18,567	4.04
4.05	15.00	PHARMACY	ST. VINCENT HEALTH - CHG	48,000	48,000	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HEALTH - CHG	368,774	368,774	4.06
4.07	30.00	ADULTS & PEDIATRICS	ST. VINCENT HEALTH - CHG	68,557	68,557	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HEALTH - CHG	40,235	40,235	4.08
4.09	0.00			0	0	4.09
4.10	65.00	RESPIRATORY THERAPY	ST. VINCENT HEALTH - CHG	12,672	12,672	4.10
4.11	76.01	ONCOLOGY	ST. VINCENT HEALTH - CHG	8,417	8,417	4.11
4.12	91.00	EMERGENCY	ST. VINCENT HEALTH - CHG	400	400	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	1,540,034	1,222,957	4.15
4.16	0.00			0	0	4.16
4.17	1.00	NEW CAP REL COSTS-BLDG & FIX	ASCENSION INTEREST	381,086	383,127	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	5,333	5,362	4.18
4.19	0.00			0	0	4.19
4.20	7.00	OPERATION OF PLANT	ASCENSION MAINTENANCE	460,768	464,124	4.20
4.21	0.00			0	0	4.21
4.22	0.00			0	0	4.22
4.23	4.00	EMPLOYEE BENEFITS DEPARTMENT	PENSION	286,615	-44,165	4.23
4.24	0.00			0	0	4.24
5.00	0		0	7,077,853	5,425,803	5.00

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

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

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

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

6.00	B	ST. VINCENT HEA	100.00	ST. VINCENT HEALTH	100.00	6.00
7.00	B	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	B	ST. VINCENT HOS	100.00	ST. VINCENT HOSPITAL	100.00	8.00
9.00	A	MEDXCEL	0.00	MEDXCEL	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/20/2017 6:09 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	-89,966	0		1.00
2.00	975,834	0		2.00
3.00	123,751	0		3.00
3.01	0	0		3.01
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	317,077	0		4.15
4.16	0	0		4.16
4.17	-2,041	9		4.17
4.18	-29	0		4.18
4.19	0	0		4.19
4.20	-3,356	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	330,780	0		4.23
4.24	0	0		4.24
5.00	1,652,050			5.00

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

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

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

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

6.00	ADMINISTRATION		6.00
7.00	ADMINISTRATION		7.00
8.00	HOSPITAL		8.00
9.00	TECHNOLOGY MGMT		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2017 6:09 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	1,350	1,350	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	249,233	249,233	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	460	460	0	0	0	4.00
5.00	91.00	EMERGENCY	701,575	0	701,575	0	0	5.00
6.00	91.00	EMERGENCY	150,000	150,000	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			1,102,618	401,043	701,575		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,350		1.00
2.00	0.00		0	0	0	0		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	249,233		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	460		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	91.00	EMERGENCY	0	0	0	150,000		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	401,043		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/20/2017 6:09 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	523,665	523,665				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	579,063		579,063			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,038,477	0	0	3,038,477		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,945,860	193,637	4,438	569,888	4,713,823	5.00
7.00	00700	OPERATION OF PLANT	2,335,389	84,983	29,892	62,162	2,512,426	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,223	6,238	0	0	39,461	8.00
9.00	00900	HOUSEKEEPING	511,371	3,802	0	0	515,173	9.00
10.00	01000	DIETARY	106,647	10,344	7,917	0	124,908	10.00
11.00	01100	CAFETERIA	302,300	6,560	0	0	308,860	11.00
13.00	01300	NURSING ADMINISTRATION	210,338	7,559	2,066	81,510	301,473	13.00
15.00	01500	PHARMACY	3,593,837	5,817	54,088	156,250	3,809,992	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	363,680	9,113	0	110,247	483,040	16.00
17.00	01700	SOCIAL SERVICE	229,639	1,796	0	75,668	307,103	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,099,729	35,645	48,430	374,074	1,557,878	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	608,703	34,995	156,235	166,055	965,988	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,082,093	22,466	187,369	408,929	1,700,857	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,031,097	9,838	0	0	1,040,935	60.00
65.00	06500	RESPIRATORY THERAPY	538,106	7,675	30,186	197,695	773,662	65.00
66.00	06600	PHYSICAL THERAPY	475,100	23,080	759	180,281	679,220	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,147	815	0	21,186	74,148	67.00
68.00	06800	SPEECH PATHOLOGY	48,945	0	0	17,959	66,904	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,704	0	0	0	81,704	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	98,951	0	0	0	98,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	29,533	3,269	7,243	11,532	51,577	76.00
76.01	03480	ONCOLOGY	177,616	1,549	0	64,795	243,960	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	328,060	6,480	346	122,089	456,975	90.00
91.00	09100	EMERGENCY	1,874,456	32,318	50,094	418,157	2,375,025	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,299,729	507,979	579,063	3,038,477	23,284,043	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,518	0	0	1,518	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,412	0	0	6,412	192.00
194.00	07950	MARKETING	328,807	3,291	0	0	332,098	194.00
194.01	07951	FOUNDATION	344	1,393	0	0	1,737	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	3,072	0	0	3,072	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)	23,628,880	523,665	579,063	3,038,477	23,628,880	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/20/2017 6:09 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,713,823					5.00
7.00	00700	OPERATION OF PLANT	626,122	3,138,548				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,834	79,895	129,190			8.00
9.00	00900	HOUSEKEEPING	128,386	48,694	28,051	720,304		9.00
10.00	01000	DIETARY	31,128	132,489	0	0	288,525	10.00
11.00	01100	CAFETERIA	76,971	84,024	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	75,130	96,814	0	7,734	0	13.00
15.00	01500	PHARMACY	949,491	74,503	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	120,378	116,716	0	7,734	0	16.00
17.00	01700	SOCIAL SERVICE	76,533	22,999	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	388,239	456,540	41,549	152,621	288,525	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	240,734	448,225	13,372	61,357	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,871	287,747	10,168	74,763	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	259,411	126,008	0	23,718	0	60.00
65.00	06500	RESPIRATORY THERAPY	192,804	98,305	0	34,030	0	65.00
66.00	06600	PHYSICAL THERAPY	169,268	295,605	10,318	119,105	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,478	10,439	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,673	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,361	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	24,660	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,859	0	73.00
76.00	03610	SLEEP LAB	12,854	41,869	457	4,125	0	76.00
76.01	03480	ONCOLOGY	60,797	19,845	0	24,749	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	113,883	82,992	66	68,060	0	90.00
91.00	09100	EMERGENCY	591,880	413,927	25,209	126,840	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,627,886	2,937,636	129,190	716,695	288,525	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	378	19,443	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,598	82,132	0	0	0	192.00
194.00	07950	MARKETING	82,762	42,155	0	1,031	0	194.00
194.01	07951	FOUNDATION	433	17,837	0	2,578	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	766	39,345	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)	4,713,823	3,138,548	129,190	720,304	288,525	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/20/2017 6:09 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	469,855					11.00
13.00	01300	NURSING ADMINISTRATION	11,770	492,921				13.00
15.00	01500	PHARMACY	0	0	4,833,986			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,792	0	0	756,660		16.00
17.00	01700	SOCIAL SERVICE	13,040	8,772	0	0	428,447	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,570	98,998	0	30,219	415,568	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,889	38,682	0	105,303	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,183	86,074	0	199,169	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	111,811	0	60.00
65.00	06500	RESPIRATORY THERAPY	40,632	47,789	0	29,607	0	65.00
66.00	06600	PHYSICAL THERAPY	36,304	42,699	0	34,659	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,140	3,693	0	3,296	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,165	228	0	3,146	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,930	22,264	4,833,986	0	0	73.00
76.00	03610	SLEEP LAB	1,730	2,034	0	3,918	0	76.00
76.01	03480	ONCOLOGY	10,355	12,179	0	15,326	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,217	32,011	0	14,410	0	90.00
91.00	09100	EMERGENCY	82,898	97,498	0	205,796	12,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	466,615	492,921	4,833,986	756,660	428,447	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	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	3,240	0	0	0	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	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)	469,855	492,921	4,833,986	756,660	428,447	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/20/2017 6:09 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,512,707	0	3,512,707		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,906,550	0	1,906,550		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,855,832	0	2,855,832		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	1,561,883	0	1,561,883		60.00
65.00	06500	RESPIRATORY THERAPY	1,216,829	0	1,216,829		65.00
66.00	06600	PHYSICAL THERAPY	1,387,178	0	1,387,178		66.00
67.00	06700	OCCUPATIONAL THERAPY	113,194	0	113,194		67.00
68.00	06800	SPEECH PATHOLOGY	90,116	0	90,116		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,065	0	102,065		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	123,611	0	123,611		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,887,039	0	4,887,039		73.00
76.00	03610	SLEEP LAB	118,564	0	118,564		76.00
76.01	03480	ONCOLOGY	387,211	0	387,211		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	795,614	0	795,614		90.00
91.00	09100	EMERGENCY	3,931,952	0	3,931,952		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,990,345	0	22,990,345		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,339	0	21,339		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	90,142	0	90,142		192.00
194.00	07950	MARKETING	458,046	0	458,046		194.00
194.01	07951	FOUNDATION	25,825	0	25,825		194.01
194.02	07952	CLINIC	0	0	0		194.02
194.03	07953	VACANT	43,183	0	43,183		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	23,628,880	0	23,628,880		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/20/2017 6:09 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	437,105	193,637	4,438	635,180	0	5.00
7.00	00700	OPERATION OF PLANT	0	84,983	29,892	114,875	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,238	0	6,238	0	8.00
9.00	00900	HOUSEKEEPING	0	3,802	0	3,802	0	9.00
10.00	01000	DIETARY	0	10,344	7,917	18,261	0	10.00
11.00	01100	CAFETERIA	0	6,560	0	6,560	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,559	2,066	9,625	0	13.00
15.00	01500	PHARMACY	0	5,817	54,088	59,905	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,113	0	9,113	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,796	0	1,796	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	35,645	48,430	84,075	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	34,995	156,235	191,230	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,466	187,369	209,835	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	9,838	0	9,838	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,675	30,186	37,861	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,080	759	23,839	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	815	0	815	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	3,269	7,243	10,512	0	76.00
76.01	03480	ONCOLOGY	0	1,549	0	1,549	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	6,480	346	6,826	0	90.00
91.00	09100	EMERGENCY	0	32,318	50,094	82,412	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	437,105	507,979	579,063	1,524,147	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,518	0	1,518	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,412	0	6,412	0	192.00
194.00	07950	MARKETING	0	3,291	0	3,291	0	194.00
194.01	07951	FOUNDATION	0	1,393	0	1,393	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	3,072	0	3,072	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)	437,105	523,665	579,063	1,539,833	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/20/2017 6:09 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	635,180					5.00
7.00	00700	OPERATION OF PLANT	84,370	199,245				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,325	5,072	12,635			8.00
9.00	00900	HOUSEKEEPING	17,300	3,091	2,743	26,936		9.00
10.00	01000	DIETARY	4,195	8,411	0	0	30,867	10.00
11.00	01100	CAFETERIA	10,372	5,334	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	10,124	6,146	0	289	0	13.00
15.00	01500	PHARMACY	127,936	4,730	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,221	7,410	0	289	0	16.00
17.00	01700	SOCIAL SERVICE	10,313	1,460	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,315	28,982	4,064	5,708	30,867	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,439	28,455	1,308	2,294	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,116	18,267	994	2,796	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	34,956	7,999	0	887	0	60.00
65.00	06500	RESPIRATORY THERAPY	25,980	6,241	0	1,273	0	65.00
66.00	06600	PHYSICAL THERAPY	22,809	18,766	1,009	4,454	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,490	663	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,247	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,744	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,323	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	443	0	73.00
76.00	03610	SLEEP LAB	1,732	2,658	45	154	0	76.00
76.01	03480	ONCOLOGY	8,192	1,260	0	926	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,346	5,269	6	2,545	0	90.00
91.00	09100	EMERGENCY	79,756	26,277	2,466	4,743	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	623,601	186,491	12,635	26,801	30,867	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	51	1,234	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	215	5,214	0	0	0	192.00
194.00	07950	MARKETING	11,152	2,676	0	39	0	194.00
194.01	07951	FOUNDATION	58	1,132	0	96	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	103	2,498	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)	635,180	199,245	12,635	26,936	30,867	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/20/2017 6:09 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	22,266					11.00
13.00	01300	NURSING ADMINISTRATION	558	26,742				13.00
15.00	01500	PHARMACY	0	0	192,571			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,364	0	0	34,397		16.00
17.00	01700	SOCIAL SERVICE	618	476	0	0	14,663	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,913	5,370	0	1,373	14,222	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,559	2,099	0	4,785	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,468	4,670	0	9,050	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	5,080	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,926	2,593	0	1,345	0	65.00
66.00	06600	PHYSICAL THERAPY	1,720	2,317	0	1,575	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	149	200	0	150	0	67.00
68.00	06800	SPEECH PATHOLOGY	150	12	0	143	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	897	1,208	192,571	0	0	73.00
76.00	03610	SLEEP LAB	82	110	0	178	0	76.00
76.01	03480	ONCOLOGY	491	661	0	696	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,290	1,737	0	655	0	90.00
91.00	09100	EMERGENCY	3,927	5,289	0	9,367	441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,112	26,742	192,571	34,397	14,663	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	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	154	0	0	0	0	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	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)	22,266	26,742	192,571	34,397	14,663	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 6:09 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	230,889	0	230,889		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	264,169	0	264,169		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	306,196	0	306,196		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	58,760	0	58,760		60.00
65.00	06500	RESPIRATORY THERAPY	77,219	0	77,219		65.00
66.00	06600	PHYSICAL THERAPY	76,489	0	76,489		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,467	0	4,467		67.00
68.00	06800	SPEECH PATHOLOGY	2,552	0	2,552		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,744	0	2,744		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,323	0	3,323		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,119	0	195,119		73.00
76.00	03610	SLEEP LAB	15,471	0	15,471		76.00
76.01	03480	ONCOLOGY	13,775	0	13,775		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	33,674	0	33,674		90.00
91.00	09100	EMERGENCY	214,678	0	214,678		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,499,525	0	1,499,525		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,803	0	2,803		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,841	0	11,841		192.00
194.00	07950	MARKETING	17,158	0	17,158		194.00
194.01	07951	FOUNDATION	2,833	0	2,833		194.01
194.02	07952	CLINIC	0	0	0		194.02
194.03	07953	VACANT	5,673	0	5,673		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,539,833	0	1,539,833		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 6:09 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DIRECT COST)	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	NEW CAP REL COSTS-BLDG & FIXT	116,942					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		579,063				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,432,813			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	43,242	4,438	1,394,072	-4,713,823	18,915,057	5.00
7.00	00700	OPERATION OF PLANT	18,978	29,892	152,063	0	2,512,426	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,393	0	0	0	39,461	8.00
9.00	00900	HOUSEKEEPING	849	0	0	0	515,173	9.00
10.00	01000	DIETARY	2,310	7,917	0	0	124,908	10.00
11.00	01100	CAFETERIA	1,465	0	0	0	308,860	11.00
13.00	01300	NURSING ADMINISTRATION	1,688	2,066	199,393	0	301,473	13.00
15.00	01500	PHARMACY	1,299	54,088	382,224	0	3,809,992	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,035	0	269,690	0	483,040	16.00
17.00	01700	SOCIAL SERVICE	401	0	185,102	0	307,103	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,960	48,430	915,071	0	1,557,878	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,815	156,235	406,208	0	965,988	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,017	187,369	1,000,336	0	1,700,857	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,197	0	0	0	1,040,935	60.00
65.00	06500	RESPIRATORY THERAPY	1,714	30,186	483,608	0	773,662	65.00
66.00	06600	PHYSICAL THERAPY	5,154	759	441,010	0	679,220	66.00
67.00	06700	OCCUPATIONAL THERAPY	182	0	51,825	0	74,148	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	43,933	0	66,904	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	81,704	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	98,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	730	7,243	28,209	0	51,577	76.00
76.01	03480	ONCOLOGY	346	0	158,504	0	243,960	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,447	346	298,657	0	456,975	90.00
91.00	09100	EMERGENCY	7,217	50,094	1,022,908	0	2,375,025	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	113,439	579,063	7,432,813	-4,713,823	18,570,220	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	0	1,518	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,432	0	0	0	6,412	192.00
194.00	07950	MARKETING	735	0	0	0	332,098	194.00
194.01	07951	FOUNDATION	311	0	0	0	1,737	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	686	0	0	0	3,072	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)	523,665	579,063	3,038,477		4,713,823	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.477989	1.000000	0.408792		0.249210	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		635,180	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.033581	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 6:09 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	54,722					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,393	126,487				8.00
9.00	00900	HOUSEKEEPING	849	27,464	1,397			9.00
10.00	01000	DIETARY	2,310	0	0	1,218		10.00
11.00	01100	CAFETERIA	1,465	0	0	0	201,275	11.00
13.00	01300	NURSING ADMINISTRATION	1,688	0	15	0	5,042	13.00
15.00	01500	PHARMACY	1,299	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,035	0	15	0	12,334	16.00
17.00	01700	SOCIAL SERVICE	401	0	0	0	5,586	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,960	40,680	296	1,218	35,371	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,815	13,092	119	0	14,089	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,017	9,955	145	0	31,350	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,197	0	46	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,714	0	66	0	17,406	65.00
66.00	06600	PHYSICAL THERAPY	5,154	10,102	231	0	15,552	66.00
67.00	06700	OCCUPATIONAL THERAPY	182	0	0	0	1,345	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,356	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	23	0	8,109	73.00
76.00	03610	SLEEP LAB	730	447	8	0	741	76.00
76.01	03480	ONCOLOGY	346	0	48	0	4,436	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,447	65	132	0	11,659	90.00
91.00	09100	EMERGENCY	7,217	24,682	246	0	35,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,219	126,487	1,390	1,218	199,887	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,432	0	0	0	0	192.00
194.00	07950	MARKETING	735	0	2	0	0	194.00
194.01	07951	FOUNDATION	311	0	5	0	1,388	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	686	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)	3,138,548	129,190	720,304	288,525	469,855	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	57.354410	1.021370	515.607731	236.884236	2.334393	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	199,245	12,635	26,936	30,867	22,266	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.641040	0.099892	19.281317	25.342365	0.110625	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 6:09 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			13.00	15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	179,533					13.00
15.00	01500	PHARMACY	0	1,000				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	55,721,127			16.00
17.00	01700	SOCIAL SERVICE	3,195	0	0	4,990		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,057	0	2,225,432	4,840		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,089	0	7,754,852	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,350	0	14,667,400	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	0	8,234,125	0		60.00
65.00	06500	RESPIRATORY THERAPY	17,406	0	2,180,325	0		65.00
66.00	06600	PHYSICAL THERAPY	15,552	0	2,552,409	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,345	0	242,728	0		67.00
68.00	06800	SPEECH PATHOLOGY	83	0	231,704	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,109	1,000	0	0		73.00
76.00	03610	SLEEP LAB	741	0	288,546	0		76.00
76.01	03480	ONCOLOGY	4,436	0	1,128,633	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,659	0	1,061,193	0		90.00
91.00	09100	EMERGENCY	35,511	0	15,153,780	150		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	179,533	1,000	55,721,127	4,990		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	CLINIC	0	0	0	0		194.02
194.03	07953	VACANT	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)	492,921	4,833,986	756,660	428,447		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.745573	4,833.986000	0.013579	85.861122		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,742	192,571	34,397	14,663		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.148953	192.571000	0.000617	2.938477		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,512,707		3,512,707	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,906,550		1,906,550	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,855,832		2,855,832	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,561,883		1,561,883	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,216,829	0	1,216,829	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,387,178	0	1,387,178	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,194	0	113,194	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	90,116	0	90,116	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,065		102,065	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	123,611		123,611	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,887,039		4,887,039	0	0	73.00
76.00	03610	SLEEP LAB	118,564		118,564	0	0	76.00
76.01	03480	ONCOLOGY	387,211		387,211	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	795,614		795,614	0	0	90.00
91.00	09100	EMERGENCY	3,931,952		3,931,952	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	812,700		812,700		0	92.00
200.00		Subtotal (see instructions)	23,803,045	0	23,803,045	0	0	200.00
201.00		Less Observation Beds	812,700		812,700		0	201.00
202.00		Total (see instructions)	22,990,345	0	22,990,345	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,738,963		1,738,963			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	961,541	6,793,311	7,754,852	0.245853	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	626,070	14,041,331	14,667,401	0.194706	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	720,496	7,513,629	8,234,125	0.189684	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	727,899	1,452,426	2,180,325	0.558095	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	119,932	2,432,476	2,552,408	0.543478	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,486	191,242	242,728	0.466341	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	38,698	193,006	231,704	0.388927	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	447,250	1,022,942	1,470,192	0.069423	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	188,508	167,005	355,513	0.347698	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	901,191	12,754,074	13,655,265	0.357887	0.000000	73.00
76.00	03610	SLEEP LAB	0	288,546	288,546	0.410902	0.000000	76.00
76.01	03480	ONCOLOGY	7,949	1,120,684	1,128,633	0.343080	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,338	1,057,855	1,061,193	0.749735	0.000000	90.00
91.00	09100	EMERGENCY	252,563	14,901,217	15,153,780	0.259470	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	25,204	461,265	486,469	1.670610	0.000000	92.00
200.00		Subtotal (see instructions)	6,811,088	64,391,009	71,202,097			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,811,088	64,391,009	71,202,097			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03610	SLEEP LAB	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,512,707		3,512,707	0	3,512,707	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,906,550		1,906,550	0	1,906,550	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,855,832		2,855,832	0	2,855,832	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,561,883		1,561,883	0	1,561,883	60.00
65.00	06500	RESPIRATORY THERAPY	1,216,829	0	1,216,829	0	1,216,829	65.00
66.00	06600	PHYSICAL THERAPY	1,387,178	0	1,387,178	0	1,387,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,194	0	113,194	0	113,194	67.00
68.00	06800	SPEECH PATHOLOGY	90,116	0	90,116	0	90,116	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,065		102,065	0	102,065	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	123,611		123,611	0	123,611	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,887,039		4,887,039	0	4,887,039	73.00
76.00	03610	SLEEP LAB	118,564		118,564	0	118,564	76.00
76.01	03480	ONCOLOGY	387,211		387,211	0	387,211	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	795,614		795,614	0	795,614	90.00
91.00	09100	EMERGENCY	3,931,952		3,931,952	0	3,931,952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	812,700		812,700		812,700	92.00
200.00		Subtotal (see instructions)	23,803,045	0	23,803,045	0	23,803,045	200.00
201.00		Less Observation Beds	812,700		812,700		812,700	201.00
202.00		Total (see instructions)	22,990,345	0	22,990,345	0	22,990,345	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,738,963		1,738,963			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	961,541	6,793,311	7,754,852	0.245853	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	626,070	14,041,331	14,667,401	0.194706	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	720,496	7,513,629	8,234,125	0.189684	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	727,899	1,452,426	2,180,325	0.558095	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	119,932	2,432,476	2,552,408	0.543478	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,486	191,242	242,728	0.466341	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	38,698	193,006	231,704	0.388927	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	447,250	1,022,942	1,470,192	0.069423	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	188,508	167,005	355,513	0.347698	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	901,191	12,754,074	13,655,265	0.357887	0.000000	73.00
76.00	03610	SLEEP LAB	0	288,546	288,546	0.410902	0.000000	76.00
76.01	03480	ONCOLOGY	7,949	1,120,684	1,128,633	0.343080	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,338	1,057,855	1,061,193	0.749735	0.000000	90.00
91.00	09100	EMERGENCY	252,563	14,901,217	15,153,780	0.259470	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	25,204	461,265	486,469	1.670610	0.000000	92.00
200.00		Subtotal (see instructions)	6,811,088	64,391,009	71,202,097			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,811,088	64,391,009	71,202,097			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03610	SLEEP LAB	0.000000	76.00
76.01	03480	ONCOLOGY	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	264,169	7,754,852	0.034065	271,350	9,244	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	306,196	14,667,401	0.020876	146,837	3,065	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	58,760	8,234,125	0.007136	280,702	2,003	60.00
65.00	06500	RESPIRATORY THERAPY	77,219	2,180,325	0.035416	408,927	14,483	65.00
66.00	06600	PHYSICAL THERAPY	76,489	2,552,408	0.029967	50,639	1,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,467	242,728	0.018403	21,075	388	67.00
68.00	06800	SPEECH PATHOLOGY	2,552	231,704	0.011014	18,488	204	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,744	1,470,192	0.001866	187,436	350	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,323	355,513	0.009347	43,275	404	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,119	13,655,265	0.014289	325,894	4,657	73.00
76.00	03610	SLEEP LAB	15,471	288,546	0.053617	0	0	76.00
76.01	03480	ONCOLOGY	13,775	1,128,633	0.012205	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,674	1,061,193	0.031732	2,721	86	90.00
91.00	09100	EMERGENCY	214,678	15,153,780	0.014167	2,956	42	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	53,419	486,469	0.109810	0	0	92.00
200.00		Total (lines 50-199)	1,322,055	69,463,134		1,760,300	36,443	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,754,852	0.000000	0.000000	271,350	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,667,401	0.000000	0.000000	146,837	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	8,234,125	0.000000	0.000000	280,702	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,180,325	0.000000	0.000000	408,927	65.00
66.00	06600	PHYSICAL THERAPY	0	2,552,408	0.000000	0.000000	50,639	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	242,728	0.000000	0.000000	21,075	67.00
68.00	06800	SPEECH PATHOLOGY	0	231,704	0.000000	0.000000	18,488	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,470,192	0.000000	0.000000	187,436	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	355,513	0.000000	0.000000	43,275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,655,265	0.000000	0.000000	325,894	73.00
76.00	03610	SLEEP LAB	0	288,546	0.000000	0.000000	0	76.00
76.01	03480	ONCOLOGY	0	1,128,633	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,061,193	0.000000	0.000000	2,721	90.00
91.00	09100	EMERGENCY	0	15,153,780	0.000000	0.000000	2,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	486,469	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	69,463,134			1,760,300	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03610	SLEEP LAB	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.245853	0	2,123,635	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194706	0	3,983,952	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.189684	0	2,622,667	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.558095	0	990,678	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.543478	0	682,851	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.466341	0	40,187	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.388927	0	44,112	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.069423	0	392,668	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.347698	0	40,509	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357887	0	4,244,090	3,619	0	73.00
76.00	03610	SLEEP LAB	0.410902	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.343080	0	192,556	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.749735	0	378,468	0	0	90.00
91.00	09100	EMERGENCY	0.259470	0	3,308,250	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.670610	0	188,998	0	0	92.00
200.00		Subtotal (see instructions)		0	19,233,621	3,619	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	19,233,621	3,619	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	522,102	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	775,699	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	497,478	0	60.00
65.00	06500	RESPIRATORY THERAPY	552,892	0	65.00
66.00	06600	PHYSICAL THERAPY	371,114	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,741	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,260	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,085	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,518,905	1,295	73.00
76.00	03610	SLEEP LAB	0	0	76.00
76.01	03480	ONCOLOGY	66,062	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	283,751	0	90.00
91.00	09100	EMERGENCY	858,392	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	315,742	0	92.00
200.00		Subtotal (see instructions)	5,839,379	1,295	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,839,379	1,295	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1308 | Component CCN: 15-Z308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.245853	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194706	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.189684	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.558095	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.543478	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.466341	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.388927	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.069423	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.347698	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357887	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0.410902	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.343080	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.749735	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.259470	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.670610	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1308 | Component CCN: 15-Z308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03610	SLEEP LAB	0	0		76.00
76.01	03480	ONCOLOGY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part III Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,415	0.00	23	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
200.00		Total (lines 30-199)	1,415		23	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,754,852	0.000000	0.000000	7,218	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,667,401	0.000000	0.000000	37,365	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	8,234,125	0.000000	0.000000	20,214	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,180,325	0.000000	0.000000	17,472	65.00
66.00	06600	PHYSICAL THERAPY	0	2,552,408	0.000000	0.000000	1,357	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	242,728	0.000000	0.000000	410	67.00
68.00	06800	SPEECH PATHOLOGY	0	231,704	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,470,192	0.000000	0.000000	8,062	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	355,513	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,655,265	0.000000	0.000000	22,272	73.00
76.00	03610	SLEEP LAB	0	288,546	0.000000	0.000000	0	76.00
76.01	03480	ONCOLOGY	0	1,128,633	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,061,193	0.000000	0.000000	249	90.00
91.00	09100	EMERGENCY	0	15,153,780	0.000000	0.000000	29,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	486,469	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	69,463,134			144,229	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03610	SLEEP LAB	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,575	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,415	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,058	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	63	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)	63	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	17	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)	17	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	510	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)	56	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)	47	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,512,707	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)	2,334	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	2,334	25.00
26.00	Total swing-bed cost (see instructions)	291,503	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,221,204	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,221,204	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)	2,276.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,161,000	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,161,000	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	568,805	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,729,805	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	127,482	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	106,994	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	234,476	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)	357	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,276.47	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	812,700	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	230,889	3,512,707	0.065730	812,700	53,419	90.00
91.00	Nursing School cost	0	3,512,707	0.000000	812,700	0	91.00
92.00	Allied health cost	0	3,512,707	0.000000	812,700	0	92.00
93.00	All other Medical Education	0	3,512,707	0.000000	812,700	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,575	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,415	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,058	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	63	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)	63	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	17	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)	17	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	23	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,512,707	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)	2,334	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	2,334	25.00
26.00	Total swing-bed cost (see instructions)	291,503	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,221,204	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,221,204	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)	2,276.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	52,359	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)	52,359	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	39,964	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	92,323	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	357	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,276.47	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	812,700	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	230,889	3,512,707	0.065730	812,700	53,419	90.00
91.00	Nursing School cost	0	3,512,707	0.000000	812,700	0	91.00
92.00	Allied health cost	0	3,512,707	0.000000	812,700	0	92.00
93.00	All other Medical Education	0	3,512,707	0.000000	812,700	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		682,635		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.245853	271,350	66,712	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194706	146,837	28,590	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.189684	280,702	53,245	60.00
65.00	06500	RESPIRATORY THERAPY	0.558095	408,927	228,220	65.00
66.00	06600	PHYSICAL THERAPY	0.543478	50,639	27,521	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.466341	21,075	9,828	67.00
68.00	06800	SPEECH PATHOLOGY	0.388927	18,488	7,190	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.069423	187,436	13,012	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.347698	43,275	15,047	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357887	325,894	116,633	73.00
76.00	03610	SLEEP LAB	0.410902	0	0	76.00
76.01	03480	ONCOLOGY	0.343080	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.749735	2,721	2,040	90.00
91.00	09100	EMERGENCY	0.259470	2,956	767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.670610	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,760,300	568,805	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,760,300		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1308 | Component CCN: 15-Z308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.245853	3,034	746	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194706	5,318	1,035	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.189684	36,019	6,832	60.00
65.00	06500	RESPIRATORY THERAPY	0.558095	55,139	30,773	65.00
66.00	06600	PHYSICAL THERAPY	0.543478	9,516	5,172	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.466341	7,790	3,633	67.00
68.00	06800	SPEECH PATHOLOGY	0.388927	6,189	2,407	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.069423	17,507	1,215	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.347698	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357887	35,057	12,546	73.00
76.00	03610	SLEEP LAB	0.410902	0	0	76.00
76.01	03480	ONCOLOGY	0.343080	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.749735	368	276	90.00
91.00	09100	EMERGENCY	0.259470	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.670610	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		175,937	64,635	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)		175,937		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/20/2017 6:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		36,758		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.245853	7,218	1,775	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194706	37,365	7,275	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.189684	20,214	3,834	60.00
65.00	06500	RESPIRATORY THERAPY	0.558095	17,472	9,751	65.00
66.00	06600	PHYSICAL THERAPY	0.543478	1,357	737	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.466341	410	191	67.00
68.00	06800	SPEECH PATHOLOGY	0.388927	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.069423	8,062	560	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.347698	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357887	22,272	7,971	73.00
76.00	03610	SLEEP LAB	0.410902	0	0	76.00
76.01	03480	ONCOLOGY	0.343080	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.749735	249	187	90.00
91.00	09100	EMERGENCY	0.259470	29,610	7,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.670610	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		144,229	39,964	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)		144,229		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/20/2017 6:09 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,840,674	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,840,674	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,899,081	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	55,827	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,355,931	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,487,323	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,487,323	30.00
31.00	Primary payer payments	1,278	31.00
32.00	Subtotal (line 30 minus line 31)	2,486,045	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)	965,487	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	627,567	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	512,093	36.00
37.00	Subtotal (see instructions)	3,113,612	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,113,612	40.00
40.01	Sequestration adjustment (see instructions)	62,272	40.01
41.00	Interim payments	3,235,994	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-184,654	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: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,166,817		3,150,694	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/27/2016	62,600	12/27/2016	85,300	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)		62,600		85,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,229,417		3,235,994	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		354,417		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		184,654	6.02
7.00	Total Medicare program liability (see instructions)		1,583,834		3,051,340	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1308 | Component CCN: 15-Z308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2017 6:09 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		194,761		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/27/2016	35,200		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)		35,200		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)		229,961		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		65,937		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		295,898		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1308	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/20/2017 6:09 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	317	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	510	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	180	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,058	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	71,202,097	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,443,438	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1308 Component CCN: 15-Z308	Period: From 07/01/2016 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 11/20/2017 6:09 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	236,821	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	65,281	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	103	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	302,102	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	302,102	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	302,102	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	165	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	301,937	0	15.00
16.00		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	301,937	0	19.00
19.01	Sequestration adjustment (see instructions)	6,039	0	19.01
20.00	Interim payments	229,961	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	65,937	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/20/2017 6:09 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,729,805	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,729,805	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,747,103	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,747,103	19.00
20.00	Deductibles (exclude professional component)	151,060	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,596,043	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,596,043	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	30,944	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,114	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,321	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,616,157	28.00
29.00		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,616,157	30.00
30.01	Sequestration adjustment (see instructions)	32,323	30.01
31.00	Interim payments	1,229,417	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	354,417	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2017 6:09 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	92,323		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	92,323	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	92,323	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	144,229	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	144,229	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	144,229	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	51,906	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	92,323	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	92,323	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	92,323	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	92,323	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	92,323	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	92,323	0	40.00
41.00	Interim payments	92,323	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/20/2017 6:09 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	20,268	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,741,164	0	0	0	4.00
5.00	Other receivable	722,895	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,496,735	0	0	0	6.00
7.00	Inventory	436,508	0	0	0	7.00
8.00	Prepaid expenses	156,309	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,580,409	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	457,300	0	0	0	12.00
13.00	Land improvements	528,489	0	0	0	13.00
14.00	Accumulated depreciation	-361,888	0	0	0	14.00
15.00	Buildings	13,449,742	0	0	0	15.00
16.00	Accumulated depreciation	-7,183,961	0	0	0	16.00
17.00	Leasehold improvements	6,859,855	0	0	0	17.00
18.00	Accumulated depreciation	-5,034,384	0	0	0	18.00
19.00	Fixed equipment	3,088,035	0	0	0	19.00
20.00	Accumulated depreciation	-2,154,949	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	5,492,513	0	0	0	23.00
24.00	Accumulated depreciation	-4,466,835	0	0	0	24.00
25.00	Minor equipment depreciable	85,642	0	0	0	25.00
26.00	Accumulated depreciation	-76,613	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)	10,682,946	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	315,888	25,658	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	315,888	25,658	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,579,243	25,658	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,275,607	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,267,408	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,955,791	0	0	0	43.00
44.00	Other current liabilities	918,900	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,417,706	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,913,808	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)	10,913,808	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,331,514	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,752,271				52.00
53.00	Specific purpose fund		25,658			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)	-1,752,271	25,658	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,579,243	25,658	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/20/2017 6:09 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		15,498,520		32,484		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,150,811				2.00
3.00	Total (sum of line 1 and line 2)		18,649,331		32,484		3.00
4.00	DONATIONS	0		16,392		0	4.00
5.00	RELEASED OPERATING	108,386		0		0	5.00
6.00	OTHER	0		116,485		0	6.00
7.00	ROUNDING	1		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)		108,387		132,877		10.00
11.00	Subtotal (line 3 plus line 10)		18,757,718		165,361		11.00
12.00	TRANSFERS FROM AFFILIATES	19,982,748		0		0	12.00
13.00	DEFERRED PENSION COST	426,087		0		0	13.00
14.00	OTHER	101,154		0		0	14.00
15.00	RELEASED CAPITAL	0		31,317		0	15.00
16.00	RELEASED OPERATING	0		108,386		0	16.00
17.00	ROUNDING	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		20,509,989		139,703		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,752,271		25,658		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	DONATIONS		0			4.00
5.00	RELEASED OPERATING		0			5.00
6.00	OTHER		0			6.00
7.00	ROUNDING		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	TRANSFERS FROM AFFILIATES		0			12.00
13.00	DEFERRED PENSION COST		0			13.00
14.00	OTHER		0			14.00
15.00	RELEASED CAPITAL		0			15.00
16.00	RELEASED OPERATING		0			16.00
17.00	ROUNDING		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: 15-1308 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/20/2017 6:09 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,553,766		2,553,766	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)	2,553,766		2,553,766	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	2,553,766		2,553,766	17.00
18.00	Ancillary services	4,791,020	47,208,108	51,999,128	18.00
19.00	Outpatient services	252,812	16,396,391	16,649,203	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		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,597,598	63,604,499	71,202,097	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,384,419		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,384,419		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1308	Period: From 07/01/2016 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/20/2017 6:09 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,202,097	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,903,726	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,298,371	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,384,419	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,913,952	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	792	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	63,259	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	3,264	17.00
18.00	Revenue from sale of medical records and abstracts	1,746	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	42,166	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	40,113	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	31,317	24.01
24.02	STATE PROGRAM REVENUE	54,202	24.02
24.03		0	24.03
24.04		0	24.04
25.00	Total other income (sum of lines 6-24)	236,859	25.00
26.00	Total (line 5 plus line 25)	3,150,811	26.00
27.00	OTHER RECURRING	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)	3,150,811	29.00