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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/30/2015 9:47 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/30/2015 Time: 9:47 am
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 CARMEL HOSPITAL (150157) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	670,455	111,788	-34,440	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	670,455	111,788	-34,440	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: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/30/2015 9:44 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13500 NORTH MERIDIAN STREET	PO Box:			1.00
2.00	City: CARMEL	State: IN	Zip Code: 46033	County: HAMILTON	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 CARMEL HOSPITAL	150157	26900	1	01/14/2004	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	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 §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	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)	Y	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	971	147	0	0	1,308	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

		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
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	Y	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
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/30/2015 9:44 am

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	712,267	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
	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/30/2015 9:44 am

		1.00	2.00	
	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	269008	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		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)	0.50	169.00

		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)	10/01/2013	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/30/2015 9:44 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/30/2015 9:44 am

		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.	Y	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	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	10/08/2015	Y	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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/30/2015 9:44 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	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.	JOHN	KUHN	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.	317-583-3236	JOHN.KUHN@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/30/2015 9:44 am

		Part B Date	
		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)	10/08/2015	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)		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.		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.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/30/2015 9:44 am

	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	128	46,720	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		128	46,720	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	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	NEONATAL INTENSIVE CARE UNIT	35.00	15	5,475	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		153	55,845	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		153				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: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/30/2015 9:44 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,575	389	11,476			1.00
2.00	HMO and other (see instructions)	1,121	1,308				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,575	389	11,476			7.00
8.00	INTENSIVE CARE UNIT	342	248	979			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	NEONATAL INTENSIVE CARE UNIT	0	293	2,025			12.00
13.00	NURSERY		187	3,071			13.00
14.00	Total (see instructions)	3,917	1,117	17,551	0.00	600.68	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	600.68	27.00
28.00	Observation Bed Days		0	2,197			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			916			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	1	852			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: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/30/2015 9:44 am

	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	1,082	309	5,914	1.00
2.00	HMO and other (see instructions)			284	350		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	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,082	309	5,914	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 11/30/2015 9:44 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	44,471,141	0	44,471,141	1,249,721.18	35.58	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		2,138,474	0	2,138,474	24,156.15	88.53	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,697,172	0	5,697,172	156,816.00	36.33	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,165,157	0	3,165,157	32,893.01	96.23	11.00
12.00	Contract labor: Top level management and other management and administrative services		410,109	0	410,109	1,940.88	211.30	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		11,836,022	0	11,836,022	233,115.00	50.77	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,201,631	0	10,201,631			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,586,452	0	1,586,452			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		595,486	0	595,486			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	312,628	0	312,628	12,289.00	25.44	26.00
27.00	Administrative & General	5.00	6,264,330	0	6,264,330	174,606.00	35.88	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	490,748	0	490,748	32,213.00	15.23	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,665,808	0	1,665,808	69,264.35	24.05	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		625,721	0	625,721	27,553.18	22.71	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,475,561	0	1,475,561	35,680.00	41.36	38.00
39.00	Central Services and Supply	14.00	313,298	0	313,298	16,669.00	18.80	39.00
40.00	Pharmacy	15.00	2,034,927	0	2,034,927	50,124.00	40.60	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II | Date/Time Prepared: 11/30/2015 9:44 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	506,309	0	506,309	13,008.00	38.92	41.00
42.00	Social Service	17.00	166,754	0	166,754	4,762.00	35.02	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 11/30/2015 9:44 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		44,624,196	0	44,624,196	1,322,382.56	33.75	1.00
2.00	Excluded area salaries (see instructions)		5,697,172	0	5,697,172	156,816.00	36.33	2.00
3.00	Subtotal salaries (line 1 minus line 2)		38,927,024	0	38,927,024	1,165,566.56	33.40	3.00
4.00	Subtotal other wages & related costs (see inst.)		15,411,288	0	15,411,288	267,948.89	57.52	4.00
5.00	Subtotal wage-related costs (see inst.)		10,201,631	0	10,201,631	0.00	26.21	5.00
6.00	Total (sum of lines 3 thru 5)		64,539,943	0	64,539,943	1,433,515.45	45.02	6.00
7.00	Total overhead cost (see instructions)		13,856,084	0	13,856,084	436,168.53	31.77	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 11/30/2015 9:44 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	955,268	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	6,272,688	8.00
9.00	Prescription Drug Plan	1,009,570	9.00
10.00	Dental, Hearing and Vision Plan	42,792	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	38,910	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	5,400	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	304,551	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	32,200	14.00
15.00	'Workers' Compensation Insurance	371,174	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,175,862	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	76,767	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	42,155	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	56,230	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,383,567	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 11/30/2015 9:44 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	165,929	10,582,278	1.00
2.00	Hospital	165,929	8,428,728	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	2,153,550	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/30/2015 9:44 am

		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)	0.231544	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,914,005	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	33,413,333	6.00
7.00	Medicaid cost (line 1 times line 6)	7,736,657	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)	5,822,652	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,822,652	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,182,314	4,856,111	8,038,425	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	736,846	1,124,403	1,861,249	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	736,846	1,124,403	1,861,249	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,588,980	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	160,911	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	6,428,069	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,488,381	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,349,630	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,172,282	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		8,651,285	8,651,285	-55,215	8,596,070	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,594,859	3,594,859	0	3,594,859	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312,628	13,210,060	13,522,688	0	13,522,688	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,264,330	13,775,682	20,040,012	55,215	20,095,227	5.00
7.00	00700	OPERATION OF PLANT	490,748	2,906,757	3,397,505	0	3,397,505	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	452,992	452,992	0	452,992	8.00
9.00	00900	HOUSEKEEPING	0	4,300,970	4,300,970	0	4,300,970	9.00
10.00	01000	DIETARY	0	2,387,963	2,387,963	-1,419,644	968,319	10.00
11.00	01100	CAFETERIA	0	0	0	1,419,644	1,419,644	11.00
13.00	01300	NURSING ADMINISTRATION	1,475,561	105,706	1,581,267	0	1,581,267	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	313,298	78,369	391,667	0	391,667	14.00
15.00	01500	PHARMACY	2,034,927	2,913,238	4,948,165	0	4,948,165	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	506,309	368,176	874,485	0	874,485	16.00
17.00	01700	SOCIAL SERVICE	166,754	74,312	241,066	0	241,066	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,091,398	1,553,106	10,644,504	-1,044,100	9,600,404	30.00
31.00	03100	INTENSIVE CARE UNIT	1,014,924	550,281	1,565,205	0	1,565,205	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,343,925	159,601	2,503,526	0	2,503,526	35.00
43.00	04300	NURSERY	0	0	0	1,044,100	1,044,100	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,706,912	10,072,670	13,779,582	0	13,779,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,705,880	1,571,810	3,277,690	0	3,277,690	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,601,046	626,398	2,227,444	0	2,227,444	54.00
54.02	05402	ULTRASOUND	201,019	4,164	205,183	0	205,183	54.02
57.00	05700	CT SCAN	484,621	86,260	570,881	0	570,881	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	371,237	155,567	526,804	0	526,804	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	65,511	3,068,910	3,134,421	0	3,134,421	60.00
65.00	06500	RESPIRATORY THERAPY	1,057,525	121,768	1,179,293	0	1,179,293	65.00
66.00	06600	PHYSICAL THERAPY	235,356	27,408	262,764	0	262,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,185	0	19,185	0	19,185	68.00
69.00	06900	ELECTROCARDIOLOGY	113,392	166,589	279,981	0	279,981	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	76,781	12,050	88,831	0	88,831	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,663,185	1,663,185	0	1,663,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,374,317	4,374,317	0	4,374,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,373	26,373	0	26,373	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,293,451	6,323,880	8,617,331	0	8,617,331	75.00
76.00	03330	ENDOSCOPY	1,211,007	1,161,201	2,372,208	0	2,372,208	76.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,616,244	713,433	2,329,677	0	2,329,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,773,969	85,259,340	124,033,309	0	124,033,309	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	91,561	364,836	456,397	0	456,397	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	290,907	5,185	296,092	0	296,092	192.00
194.00	07950	MISSION EFFECTIVENESS	0	5,988	5,988	0	5,988	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	598	598	0	598	194.02
194.04	07954	SCHOOL NURSE	17,290	1,242	18,532	0	18,532	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	5,297,414	1,232,605	6,530,019	0	6,530,019	194.06
200.00		TOTAL (SUM OF LINES 118-199)	44,471,141	86,869,794	131,340,935	0	131,340,935	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,308,201	7,287,869	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-49,623	3,545,236	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-285,636	13,237,052	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	74,301	20,169,528	5.00
7.00	00700	OPERATION OF PLANT	-191,495	3,206,010	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	452,992	8.00
9.00	00900	HOUSEKEEPING	-399	4,300,571	9.00
10.00	01000	DIETARY	-180	968,139	10.00
11.00	01100	CAFETERIA	-516,454	903,190	11.00
13.00	01300	NURSING ADMINISTRATION	-219	1,581,048	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	391,667	14.00
15.00	01500	PHARMACY	0	4,948,165	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	874,485	16.00
17.00	01700	SOCIAL SERVICE	0	241,066	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,046,936	7,553,468	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,565,205	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-1,222,538	1,280,988	35.00
43.00	04300	NURSERY	0	1,044,100	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,096,625	12,682,957	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,177,570	2,100,120	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-198,911	2,028,533	54.00
54.02	05402	ULTRASOUND	0	205,183	54.02
57.00	05700	CT SCAN	-15,170	555,711	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	526,804	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	3,134,421	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,179,293	65.00
66.00	06600	PHYSICAL THERAPY	0	262,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,185	68.00
69.00	06900	ELECTROCARDIOLOGY	0	279,981	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	88,831	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,663,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,374,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,373	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-208,734	8,408,597	75.00
76.00	03330	ENDOSCOPY	19,767	2,391,975	76.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-124,912	2,204,765	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,349,535	115,683,774	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	456,397	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	296,092	192.00
194.00	07950	MISSION EFFECTIVENESS	0	5,988	194.00
194.01	07951	MARKETING	1,727,876	1,727,876	194.01
194.02	07952	JOINT VENTURES	0	598	194.02
194.04	07954	SCHOOL NURSE	0	18,532	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	6,530,019	194.06
200.00		TOTAL (SUM OF LINES 118-199)	-6,621,659	124,719,276	200.00

RECLASSIFICATIONS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 Date/Time Prepared: 11/30/2015 9:44 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - NURSERY				
1.00	NURSERY	43.00	917,896	126,204	1.00
	TOTALS		917,896	126,204	
	B - INTEREST EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	55,215	1.00
	TOTALS		0	55,215	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	0	1,419,644	1.00
	TOTALS		0	1,419,644	
500.00	Grand Total: Increases		917,896	1,601,063	500.00

RECLASSIFICATIONS

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/30/2015 9:44 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - NURSERY					
1.00	ADULTS & PEDIATRICS	30.00	917,896	126,204	0	1.00
	TOTALS		917,896	126,204		
	B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	55,215	11	1.00
	TOTALS		0	55,215		
	C - CAFETERIA					
1.00	DIETARY	10.00	0	1,419,644	0	1.00
	TOTALS		0	1,419,644		
500.00	Grand Total: Decreases		917,896	1,601,063		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/30/2015 9:44 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,111,746	0	0	0	0	1.00
2.00	Land Improvements	2,224,113	43,581	0	43,581	0	2.00
3.00	Buildings and Fixtures	35,500,660	18,299,411	0	18,299,411	0	3.00
4.00	Building Improvements	34,099,609	4,518,736	0	4,518,736	3,298	4.00
5.00	Fixed Equipment	2,791,447	33,344	0	33,344	0	5.00
6.00	Movable Equipment	31,244,238	12,321,148	0	12,321,148	2,090,401	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	107,971,813	35,216,220	0	35,216,220	2,093,699	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	107,971,813	35,216,220	0	35,216,220	2,093,699	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,111,746	0	1.00
2.00	Land Improvements	2,267,694	1,609,024	2.00
3.00	Buildings and Fixtures	53,800,071	49,990,202	3.00
4.00	Building Improvements	38,615,047	12,995,175	4.00
5.00	Fixed Equipment	2,824,791	1,033,601	5.00
6.00	Movable Equipment	41,474,985	21,281,206	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	141,094,334	86,909,208	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	141,094,334	86,909,208	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II Date/Time Prepared: 11/30/2015 9:44 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,162,935	4,647,838	655,953	65,252	119,307	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,983,839	608,297	0	2,723	0	2.00
3.00	Total (sum of lines 1-2)	6,146,774	5,256,135	655,953	67,975	119,307	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	8,651,285	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,594,859	2.00
3.00	Total (sum of lines 1-2)	0	12,246,144	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III | Date/Time Prepared: 11/30/2015 9:44 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	73,936,128	0	73,936,128	0.684772	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,035,685	0	34,035,685	0.315228	0	2.00
3.00	Total (sum of lines 1-2)	107,971,813	0	107,971,813	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,695,522	3,967,696	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,983,839	608,297	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,679,361	4,575,993	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	458,682	65,252	119,307	-18,590	7,287,869	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,723	0	-49,623	3,545,236	2.00
3.00	Total (sum of lines 1-2)	458,682	67,975	119,307	-68,213	10,833,105	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/30/2015 9:44 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-467,413	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	A	-48,498	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,186,282			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	6,590,384			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-516,454	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
34.00	OTHER MISC REVENUE - BENEFITS	B	-10,222	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/30/2015 9:44 am

	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	
35.00	OTHER MISC REVENUE - ADMIN	B	-13,646	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER MISC REVENUE - MAINT	B	-67,331	OPERATION OF PLANT	7.00	0	36.00
37.00	OTHER MISC REVENUE - HKPG	B	-399	HOUSEKEEPING	9.00	0	37.00
38.00	OTHER MISC REVENUE - DIETARY	B	-180	DIETARY	10.00	0	38.00
39.00	OTHER MISC REVENUE - ROUTINE	B	-135,336	ADULTS & PEDIATRICS	30.00	0	39.00
40.00	OTHER MISC REVENUE - NEONATOLOGY	B	-23	NEONATAL INTENSIVE CARE UNIT	35.00	0	40.00
41.00	OTHER MISC REVENUE - RADIOLOGY	B	-1,200	RADIOLOGY-DIAGNOSTIC	54.00	0	41.00
42.00	OTHER MISC REVENUE - ASC	B	-208,734	ASC (NON-DISTINCT PART)	75.00	0	42.00
43.00	PROPERTY RENTAL INCOME	B	-680,142	CAP REL COSTS-BLDG & FIXT	1.00	10	43.00
44.00	PROVIDER ASSESSMENT OFFSET	A	-2,702,440	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	LOBBYING	A	-3,438	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	LOSS ON SALE OF PPE	A	-49,623	CAP REL COSTS-MVBLE EQUIP	2.00	14	46.00
47.00	CONSOLIDATING ENTRY	B	-1,501,251	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00			0		0.00	0	48.00
49.00	OTHER MISC REVENUE - ENDO	B	19,767	ENDOSCOPY	76.00	0	49.00
49.01	IFUE OPERATING COMFORT IMAGING	B	-18,590	CAP REL COSTS-BLDG & FIXT	1.00	14	49.01
49.02			0		0.00	0	49.02
49.03	NONRECURRING OP EXPENSES	B	27,887	ADMINISTRATIVE & GENERAL	5.00	0	49.03
49.04	ENTERTAINMENT EXP - BENEFITS	A	-318	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.04
49.05	ENTERTAINMENT EXP - ADMIN	A	-4	ADMINISTRATIVE & GENERAL	5.00	0	49.05
49.06	ENTERTAINMENT EXP - NURS ADMIN	A	-219	NURSING ADMINISTRATION	13.00	0	49.06
49.07	ENTERTAINMENT EXP - ROUTINE	A	-621	ADULTS & PEDIATRICS	30.00	0	49.07
49.08	ENTERTAINMENT EXP - NEONATE	A	-125	NEONATAL INTENSIVE CARE UNIT	35.00	0	49.08
49.09	ENTERTAINMENT EXP - OR	A	-1,877	OPERATING ROOM	50.00	0	49.09
49.10	ENTERTAINMENT EXP - RADIOLOGY	A	-439	RADIOLOGY-DIAGNOSTIC	54.00	0	49.10
49.11	ENTERTAINMENT EXP - ER	A	-245	EMERGENCY	91.00	0	49.11
49.12	INCENTIVE PYMT ADJ - SALARIES	A	-590,953	ADMINISTRATIVE & GENERAL	5.00	0	49.12
49.13	INCENTIVE PYMT ADJ - FICA	A	-53,694	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,621,659				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: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 Date/Time Prepared: 11/30/2015 9:44 am

	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	H.O. COSTS	0	596,212	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	H.O. COSTS	13,301,395	7,951,265	2.00
3.00	194.01	MARKETING	H.O. COSTS MARKETING	1,727,876	0	3.00
3.01	1.00	CAP REL COSTS-BLDG & FIXT	SVH CHARGEBACK	-3,780	-3,780	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	761,144	761,144	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	3,055,335	3,055,335	3.03
4.00	13.00	NURSING ADMINISTRATION	SVH CHARGEBACK	92,196	92,196	4.00
4.01	15.00	PHARMACY	SVH CHARGEBACK	-14,196	-14,196	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACK	706,966	706,966	4.02
4.03	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACK	19,405	19,405	4.03
4.04	31.00	INTENSIVE CARE UNIT	SVH CHARGEBACK	401,496	401,496	4.04
4.05	50.00	OPERATING ROOM	SVH CHARGEBACK	975	975	4.05
4.06	52.00	DELIVERY ROOM & LABOR ROOM	SVH CHARGEBACK	50	50	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	59,564	59,564	4.07
4.08	66.00	PHYSICAL THERAPY	SVH CHARGEBACK	-28,884	-28,884	4.08
4.10	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	34,896	34,896	4.10
4.11	76.00	ENDOSCOPY	SVH CHARGEBACK	275	275	4.11
4.12	91.00	EMERGENCY	SVH CHARGEBACK	175	175	4.12
4.13	190.00	GIFT, FLOWER, COFFEE SHOP &	SVH CHARGEBACK	24,058	24,058	4.13
4.14	194.06	SPORTS MEDICINE & OB PHYS	SVH CHARGEBACK	391,252	391,252	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	5,682,561	6,144,933	4.15
4.16	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	513,897	655,953	4.16
4.17	7.00	OPERATION OF PLANT	TRIMEDX	3,109,906	3,234,070	4.17
4.18	4.00	EMPLOYEE BENEFITS DEPARTMENT	PENSION	1,829,348	992,166	4.18
4.20	0.00			0	0	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			31,665,910	25,075,526	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-1 Date/Time Prepared: 11/30/2015 9:44 am

	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	-596,212	0	1.00
2.00	5,350,130	0	2.00
3.00	1,727,876	0	3.00
3.01	0	9	3.01
3.02	0	0	3.02
3.03	0	0	3.03
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
4.10	0	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	0	9	4.13
4.14	0	0	4.14
4.15	-462,372	0	4.15
4.16	-142,056	11	4.16
4.17	-124,164	0	4.17
4.18	837,182	0	4.18
4.20	0	0	4.20
5.00	6,590,384		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	HOME OFFICE	6.00
7.00	HOME OFFICE	7.00
8.00	TECHNOLOGY MGMT	8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 Date/Time Prepared: 11/30/2015 9:44 am

	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	443,486	443,486	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,910,979	1,910,979	0	0	0	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	1,222,390	1,222,390	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,094,748	1,094,748	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	1,177,570	1,177,570	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	5,031	5,031	0	0	0	6.00
7.00	57.00	CT SCAN	15,170	15,170	0	0	0	7.00
8.00	91.00	EMERGENCY	124,667	124,667	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	192,241	192,241	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,186,282	6,186,282	0		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	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	443,486		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,910,979		2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	1,222,390		3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,094,748		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,177,570		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,031		6.00
7.00	57.00	CT SCAN	0	0	0	15,170		7.00
8.00	91.00	EMERGENCY	0	0	0	124,667		8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	192,241		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	6,186,282		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,287,869	7,287,869				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,545,236		3,545,236			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,237,052	95,906	1,201	13,334,159		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,169,528	463,036	417,873	1,891,583	22,942,020	5.00
7.00	00700	OPERATION OF PLANT	3,206,010	851,220	41,065	148,187	4,246,482	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	452,992	31,519	0	0	484,511	8.00
9.00	00900	HOUSEKEEPING	4,300,571	136,862	0	0	4,437,433	9.00
10.00	01000	DIETARY	968,139	160,072	5,652	0	1,133,863	10.00
11.00	01100	CAFETERIA	903,190	186,763	8,282	0	1,098,235	11.00
13.00	01300	NURSING ADMINISTRATION	1,581,048	3,358	17,508	445,562	2,047,476	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	391,667	162,352	14,222	94,604	662,845	14.00
15.00	01500	PHARMACY	4,948,165	127,769	186,873	614,469	5,877,276	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	874,485	7,426	0	152,886	1,034,797	16.00
17.00	01700	SOCIAL SERVICE	241,066	17,622	0	50,353	309,041	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,553,468	1,652,614	228,278	2,468,088	11,902,448	30.00
31.00	03100	INTENSIVE CARE UNIT	1,565,205	169,337	36,152	306,467	2,077,161	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,280,988	168,553	12,293	707,774	2,169,608	35.00
43.00	04300	NURSERY	1,044,100	299,606	30,754	277,169	1,651,629	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,682,957	649,800	1,263,257	1,119,343	15,715,357	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,100,120	345,169	9,669	515,109	2,970,067	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,028,533	319,679	197,087	483,453	3,028,752	54.00
54.02	05402	ULTRASOUND	205,183	50,465	20,781	60,700	337,129	54.02
57.00	05700	CT SCAN	555,711	81,936	54,558	146,337	838,542	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	526,804	195,293	310,923	112,099	1,145,119	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,134,421	118,308	3,376	19,782	3,275,887	60.00
65.00	06500	RESPIRATORY THERAPY	1,179,293	50,049	64,361	319,331	1,613,034	65.00
66.00	06600	PHYSICAL THERAPY	262,764	46,691	691	71,068	381,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,185	3,407	0	5,793	28,385	68.00
69.00	06900	ELECTROCARDIOLOGY	279,981	11,127	15,280	34,240	340,628	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	88,831	3,774	13,445	23,185	129,235	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,663,185	0	0	0	1,663,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,374,317	0	0	0	4,374,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,373	0	0	0	26,373	73.00
75.00	07500	ASC (NON-DISTINCT PART)	8,408,597	310,709	225,486	692,533	9,637,325	75.00
76.00	03330	ENDOSCOPY	2,391,975	128,945	211,568	365,677	3,098,165	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,204,765	333,699	39,983	488,043	3,066,490	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)	115,683,774	7,183,066	3,430,618	11,613,835	113,744,029	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	456,397	40,539	4,556	27,648	529,140	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	296,092	0	0	87,843	383,935	192.00
194.00	07950	MISSION EFFECTIVENESS	5,988	0	3,445	0	9,433	194.00
194.01	07951	MARKETING	1,727,876	0	0	0	1,727,876	194.01
194.02	07952	JOINT VENTURES	598	0	0	0	598	194.02
194.04	07954	SCHOOL NURSE	18,532	21,691	0	5,221	45,444	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	6,530,019	42,573	106,617	1,599,612	8,278,821	194.06
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	124,719,276	7,287,869	3,545,236	13,334,159	124,719,276	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,942,020					5.00
7.00	00700	OPERATION OF PLANT	957,216	5,203,698				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,216	27,905	621,632			8.00
9.00	00900	HOUSEKEEPING	1,000,260	121,168	0	5,558,861		9.00
10.00	01000	DIETARY	255,589	141,717	0	155,854	1,687,023	10.00
11.00	01100	CAFETERIA	247,558	165,347	0	181,841	0	11.00
13.00	01300	NURSING ADMINISTRATION	461,530	2,973	0	3,269	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	149,415	143,735	17,777	158,073	0	14.00
15.00	01500	PHARMACY	1,324,820	113,117	0	124,402	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	233,258	6,575	0	7,231	0	16.00
17.00	01700	SOCIAL SERVICE	69,662	15,602	0	17,158	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,682,978	1,463,102	186,645	1,609,061	1,466,127	30.00
31.00	03100	INTENSIVE CARE UNIT	468,221	149,919	24,209	164,874	79,104	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	489,060	149,225	0	164,111	0	35.00
43.00	04300	NURSERY	372,300	265,249	28,705	291,710	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,542,463	575,286	73,837	632,675	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	669,495	305,588	62,394	336,073	141,792	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	682,723	283,021	13,054	311,254	0	54.00
54.02	05402	ULTRASOUND	75,994	44,678	1,203	49,135	0	54.02
57.00	05700	CT SCAN	189,019	72,540	3,346	79,776	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	258,126	172,898	49,149	190,146	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	738,431	104,741	0	115,190	0	60.00
65.00	06500	RESPIRATORY THERAPY	363,600	44,310	523	48,730	0	65.00
66.00	06600	PHYSICAL THERAPY	85,931	41,337	1,116	45,460	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,398	3,016	82	3,317	0	68.00
69.00	06900	ELECTROCARDIOLOGY	76,782	9,851	124	10,834	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,131	3,342	39	3,675	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	374,905	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	986,032	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,945	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,172,388	275,079	33,422	302,520	0	75.00
76.00	03330	ENDOSCOPY	698,370	114,159	29,662	125,547	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	691,230	295,433	91,982	324,904	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)	20,468,046	5,110,913	617,269	5,456,820	1,687,023	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	119,276	35,890	0	39,471	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	86,544	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	2,126	0	0	0	0	194.00
194.01	07951	MARKETING	389,487	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	135	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	10,244	19,204	0	21,119	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,866,162	37,691	4,363	41,451	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,942,020	5,203,698	621,632	5,558,861	1,687,023	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,692,981					11.00
13.00	01300	NURSING ADMINISTRATION	58,055	2,573,303				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,734	0	1,162,579			14.00
15.00	01500	PHARMACY	85,836	0	7,737	7,533,188		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,817	0	0	0	1,303,678	16.00
17.00	01700	SOCIAL SERVICE	7,927	0	41	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	386,621	791,659	23,988	5,754	120,383	30.00
31.00	03100	INTENSIVE CARE UNIT	46,784	95,796	5,331	2,216	17,115	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	68,591	140,448	5,296	6,162	39,122	35.00
43.00	04300	NURSERY	51,768	106,002	0	0	22,271	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	202,861	415,383	497,237	536,436	397,869	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	92,679	189,772	20,521	10,538	83,010	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,460	0	15,940	3,890	55,322	54.00
54.02	05402	ULTRASOUND	7,168	0	92	0	9,849	54.02
57.00	05700	CT SCAN	22,790	0	789	0	22,406	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,785	0	461	576	10,878	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,204	0	48	62,376	89,363	60.00
65.00	06500	RESPIRATORY THERAPY	56,522	0	5,099	5,416	14,634	65.00
66.00	06600	PHYSICAL THERAPY	11,985	0	606	267	6,706	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	921	0	0	0	463	68.00
69.00	06900	ELECTROCARDIOLOGY	6,985	0	29	0	8,247	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,845	0	717	0	7,159	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	102,374	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	269,252	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,308,294	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	155,535	537,452	219,615	75.00
76.00	03330	ENDOSCOPY	57,000	116,715	31,581	25,791	73,319	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	81,791	167,477	16,181	12,578	105,947	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,420,129	2,023,252	1,158,855	7,517,746	1,303,678	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,469	0	188	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,065	0	22	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	35,447	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	251,318	514,604	3,514	15,442	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,692,981	2,573,303	1,162,579	7,533,188	1,303,678	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	419,431					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	94,143	20,732,909	0	20,732,909		30.00
31.00	03100	INTENSIVE CARE UNIT	43,042	3,173,772	0	3,173,772		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	69,875	3,301,498	0	3,301,498		35.00
43.00	04300	NURSERY	0	2,789,634	0	2,789,634		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,240	22,597,644	0	22,597,644		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,063	4,934,992	0	4,934,992		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,486,416	0	4,486,416		54.00
54.02	05402	ULTRASOUND	0	525,248	0	525,248		54.02
57.00	05700	CT SCAN	0	1,229,208	0	1,229,208		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,849,138	0	1,849,138		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	4,389,240	0	4,389,240		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,151,868	0	2,151,868		65.00
66.00	06600	PHYSICAL THERAPY	0	574,622	0	574,622		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	42,582	0	42,582		68.00
69.00	06900	ELECTROCARDIOLOGY	0	453,480	0	453,480		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	177,143	0	177,143		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,140,464	0	2,140,464		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,629,601	0	5,629,601		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,340,612	0	6,340,612		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	13,333,336	0	13,333,336		75.00
76.00	03330	ENDOSCOPY	21,974	4,392,283	0	4,392,283		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	107,090	4,961,103	0	4,961,103		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)	397,427	110,206,793	0	110,206,793		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	732,434	0	732,434		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,004	505,570	0	505,570		192.00
194.00	07950	MISSION EFFECTIVENESS	0	11,559	0	11,559		194.00
194.01	07951	MARKETING	0	2,117,363	0	2,117,363		194.01
194.02	07952	JOINT VENTURES	0	733	0	733		194.02
194.04	07954	SCHOOL NURSE	0	131,458	0	131,458		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	11,013,366	0	11,013,366		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	419,431	124,719,276	0	124,719,276		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	95,906	1,201	97,107	97,107	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,876,416	463,036	417,873	2,757,325	13,775	5.00
7.00	00700	OPERATION OF PLANT	0	851,220	41,065	892,285	1,079	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	31,519	0	31,519	0	8.00
9.00	00900	HOUSEKEEPING	0	136,862	0	136,862	0	9.00
10.00	01000	DIETARY	0	160,072	5,652	165,724	0	10.00
11.00	01100	CAFETERIA	0	186,763	8,282	195,045	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,358	17,508	20,866	3,245	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	162,352	14,222	176,574	689	14.00
15.00	01500	PHARMACY	0	127,769	186,873	314,642	4,475	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,426	0	7,426	1,113	16.00
17.00	01700	SOCIAL SERVICE	0	17,622	0	17,622	367	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,652,614	228,278	1,880,892	17,978	30.00
31.00	03100	INTENSIVE CARE UNIT	0	169,337	36,152	205,489	2,232	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	168,553	12,293	180,846	5,154	35.00
43.00	04300	NURSERY	0	299,606	30,754	330,360	2,018	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	649,800	1,263,257	1,913,057	8,151	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	345,169	9,669	354,838	3,751	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	319,679	197,087	516,766	3,521	54.00
54.02	05402	ULTRASOUND	0	50,465	20,781	71,246	442	54.02
57.00	05700	CT SCAN	0	81,936	54,558	136,494	1,066	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	195,293	310,923	506,216	816	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	118,308	3,376	121,684	144	60.00
65.00	06500	RESPIRATORY THERAPY	0	50,049	64,361	114,410	2,325	65.00
66.00	06600	PHYSICAL THERAPY	0	46,691	691	47,382	518	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,407	0	3,407	42	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,127	15,280	26,407	249	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,774	13,445	17,219	169	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	310,709	225,486	536,195	5,043	75.00
76.00	03330	ENDOSCOPY	0	128,945	211,568	340,513	2,663	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	333,699	39,983	373,682	3,554	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)	1,876,416	7,183,066	3,430,618	12,490,100	84,579	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,539	4,556	45,095	201	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	640	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	3,445	3,445	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	21,691	0	21,691	38	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	42,573	106,617	149,190	11,649	194.06
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,876,416	7,287,869	3,545,236	12,709,521	97,107	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,771,100					5.00
7.00	00700	OPERATION OF PLANT	115,619	1,008,983				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,192	5,411	50,122			8.00
9.00	00900	HOUSEKEEPING	120,818	23,494	0	281,174		9.00
10.00	01000	DIETARY	30,872	27,478	0	7,883	231,957	10.00
11.00	01100	CAFETERIA	29,902	32,060	0	9,198	0	11.00
13.00	01300	NURSING ADMINISTRATION	55,747	576	0	165	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,047	27,870	1,433	7,996	0	14.00
15.00	01500	PHARMACY	160,021	21,933	0	6,292	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,174	1,275	0	366	0	16.00
17.00	01700	SOCIAL SERVICE	8,414	3,025	0	868	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	324,068	283,694	15,049	81,389	201,585	30.00
31.00	03100	INTENSIVE CARE UNIT	56,555	29,069	1,952	8,340	10,876	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	59,072	28,934	0	8,301	0	35.00
43.00	04300	NURSERY	44,969	51,431	2,314	14,755	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	427,892	111,546	5,953	32,001	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	80,866	59,253	5,031	16,999	19,496	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	82,464	54,877	1,053	15,744	0	54.00
54.02	05402	ULTRASOUND	9,179	8,663	97	2,485	0	54.02
57.00	05700	CT SCAN	22,831	14,065	270	4,035	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	31,178	33,524	3,963	9,618	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	89,193	20,309	0	5,826	0	60.00
65.00	06500	RESPIRATORY THERAPY	43,918	8,591	42	2,465	0	65.00
66.00	06600	PHYSICAL THERAPY	10,379	8,015	90	2,299	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	773	585	7	168	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,274	1,910	10	548	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,519	648	3	186	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,284	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,100	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	718	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	262,395	53,337	2,695	15,302	0	75.00
76.00	03330	ENDOSCOPY	84,354	22,135	2,392	6,350	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	83,491	57,284	7,416	16,434	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)	2,472,278	990,992	49,770	276,013	231,957	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,407	6,959	0	1,996	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,453	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	257	0	0	0	0	194.00
194.01	07951	MARKETING	47,045	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	16	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	1,237	3,724	0	1,068	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	225,407	7,308	352	2,097	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,771,100	1,008,983	50,122	281,174	231,957	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	266,205					11.00
13.00	01300	NURSING ADMINISTRATION	9,129	89,728				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,833	0	237,442			14.00
15.00	01500	PHARMACY	13,497	0	1,580	522,440		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,431	0	0	0	41,785	16.00
17.00	01700	SOCIAL SERVICE	1,246	0	8	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,792	27,604	4,899	399	3,865	30.00
31.00	03100	INTENSIVE CARE UNIT	7,356	3,340	1,089	154	549	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	10,785	4,897	1,082	427	1,256	35.00
43.00	04300	NURSERY	8,140	3,696	0	0	715	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,898	14,484	101,559	37,203	12,706	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,573	6,617	4,191	731	2,665	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,538	0	3,255	270	1,776	54.00
54.02	05402	ULTRASOUND	1,127	0	19	0	316	54.02
57.00	05700	CT SCAN	3,583	0	161	0	719	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,425	0	94	40	349	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	504	0	10	4,326	2,869	60.00
65.00	06500	RESPIRATORY THERAPY	8,888	0	1,041	376	470	65.00
66.00	06600	PHYSICAL THERAPY	1,885	0	124	18	215	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	145	0	0	0	15	68.00
69.00	06900	ELECTROCARDIOLOGY	1,098	0	6	0	265	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	605	0	146	0	230	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	20,908	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	54,990	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	437,491	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	31,765	37,273	7,050	75.00
76.00	03330	ENDOSCOPY	8,963	4,070	6,450	1,789	2,354	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	12,861	5,840	3,305	872	3,401	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	223,302	70,548	236,682	521,369	41,785	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,332	0	38	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,054	0	4	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	1,236	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	39,517	17,944	718	1,071	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	266,205	89,728	237,442	522,440	41,785	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	31,550					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,081	2,909,295	0	2,909,295		30.00
31.00	03100	INTENSIVE CARE UNIT	3,238	330,239	0	330,239		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	5,256	306,010	0	306,010		35.00
43.00	04300	NURSERY	0	458,398	0	458,398		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	620	2,697,070	0	2,697,070		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,991	573,002	0	573,002		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	694,264	0	694,264		54.00
54.02	05402	ULTRASOUND	0	93,574	0	93,574		54.02
57.00	05700	CT SCAN	0	183,224	0	183,224		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	589,223	0	589,223		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	244,865	0	244,865		60.00
65.00	06500	RESPIRATORY THERAPY	0	182,526	0	182,526		65.00
66.00	06600	PHYSICAL THERAPY	0	70,925	0	70,925		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,142	0	5,142		68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,767	0	39,767		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,725	0	22,725		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,192	0	66,192		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	174,090	0	174,090		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	438,209	0	438,209		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	951,055	0	951,055		75.00
76.00	03330	ENDOSCOPY	1,653	483,686	0	483,686		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,056	576,196	0	576,196		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)	29,895	12,089,677	0	12,089,677		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	70,028	0	70,028		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,655	14,806	0	14,806		192.00
194.00	07950	MISSION EFFECTIVENESS	0	3,702	0	3,702		194.00
194.01	07951	MARKETING	0	47,045	0	47,045		194.01
194.02	07952	JOINT VENTURES	0	16	0	16		194.02
194.04	07954	SCHOOL NURSE	0	28,994	0	28,994		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	455,253	0	455,253		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	31,550	12,709,521	0	12,709,521		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	297,347					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,593,094				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,913	1,217	44,158,513			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,892	423,514	6,264,330	-22,942,020	101,777,256	5.00
7.00	00700	OPERATION OF PLANT	34,730	41,619	490,748	0	4,246,482	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,286	0	0	0	484,511	8.00
9.00	00900	HOUSEKEEPING	5,584	0	0	0	4,437,433	9.00
10.00	01000	DIETARY	6,531	5,728	0	0	1,133,863	10.00
11.00	01100	CAFETERIA	7,620	8,394	0	0	1,098,235	11.00
13.00	01300	NURSING ADMINISTRATION	137	17,744	1,475,561	0	2,047,476	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	14,414	313,298	0	662,845	14.00
15.00	01500	PHARMACY	5,213	189,396	2,034,927	0	5,877,276	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	506,309	0	1,034,797	16.00
17.00	01700	SOCIAL SERVICE	719	0	166,754	0	309,041	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,427	231,359	8,173,502	0	11,902,448	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	36,640	1,014,924	0	2,077,161	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	12,459	2,343,925	0	2,169,608	35.00
43.00	04300	NURSERY	12,224	31,169	917,896	0	1,651,629	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	1,280,313	3,706,912	0	15,715,357	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	9,800	1,705,880	0	2,970,067	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,043	199,747	1,601,046	0	3,028,752	54.00
54.02	05402	ULTRASOUND	2,059	21,062	201,019	0	337,129	54.02
57.00	05700	CT SCAN	3,343	55,294	484,621	0	838,542	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	315,120	371,237	0	1,145,119	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	3,422	65,511	0	3,275,887	60.00
65.00	06500	RESPIRATORY THERAPY	2,042	65,230	1,057,525	0	1,613,034	65.00
66.00	06600	PHYSICAL THERAPY	1,905	700	235,356	0	381,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	139	0	19,185	0	28,385	68.00
69.00	06900	ELECTROCARDIOLOGY	454	15,486	113,392	0	340,628	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	154	13,626	76,781	0	129,235	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,663,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,374,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	26,373	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	228,530	2,293,451	0	9,637,325	75.00
76.00	03330	ENDOSCOPY	5,261	214,424	1,211,007	0	3,098,165	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	40,523	1,616,244	0	3,066,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	293,071	3,476,930	38,461,341	-22,942,020	90,802,009	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	4,617	91,561	0	529,140	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	290,907	0	383,935	192.00
194.00	07950	MISSION EFFECTIVENESS	0	3,491	0	0	9,433	194.00
194.01	07951	MARKETING	0	0	0	0	1,727,876	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	598	194.02
194.04	07954	SCHOOL NURSE	885	0	17,290	0	45,444	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,737	108,056	5,297,414	0	8,278,821	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,287,869	3,545,236	13,334,159		22,942,020	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.509644	0.986681	0.301961		0.225414	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			97,107		2,771,100	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002199		0.027227	205.00

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	239,812					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,286	494,597				8.00
9.00	00900	HOUSEKEEPING	5,584	0	232,942			9.00
10.00	01000	DIETARY	6,531	0	6,531	41,928		10.00
11.00	01100	CAFETERIA	7,620	0	7,620	0	990,773	11.00
13.00	01300	NURSING ADMINISTRATION	137	0	137	0	33,975	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	14,144	6,624	0	17,986	14.00
15.00	01500	PHARMACY	5,213	0	5,213	0	50,233	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	303	0	12,768	16.00
17.00	01700	SOCIAL SERVICE	719	0	719	0	4,639	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,427	148,504	67,427	36,438	226,261	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	19,262	6,909	1,966	27,379	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	0	6,877	0	40,141	35.00
43.00	04300	NURSERY	12,224	22,839	12,224	0	30,296	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	58,748	26,512	0	118,719	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	49,643	14,083	3,524	54,238	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,043	10,386	13,043	0	54,110	54.00
54.02	05402	ULTRASOUND	2,059	957	2,059	0	4,195	54.02
57.00	05700	CT SCAN	3,343	2,662	3,343	0	13,337	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	39,105	7,968	0	12,749	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	0	4,827	0	1,875	60.00
65.00	06500	RESPIRATORY THERAPY	2,042	416	2,042	0	33,078	65.00
66.00	06600	PHYSICAL THERAPY	1,905	888	1,905	0	7,014	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	139	65	139	0	539	68.00
69.00	06900	ELECTROCARDIOLOGY	454	99	454	0	4,088	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	154	31	154	0	2,250	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	26,592	12,677	0	0	75.00
76.00	03330	ENDOSCOPY	5,261	23,600	5,261	0	33,358	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	73,185	13,615	0	47,866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	235,536	491,126	228,666	41,928	831,094	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	1,654	0	4,956	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	7,646	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	885	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,737	3,471	1,737	0	147,077	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,203,698	621,632	5,558,861	1,687,023	1,692,981	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.699073	1.256845	23.863713	40.236191	1.708748	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,008,983	50,122	281,174	231,957	266,205	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.207392	0.101339	1.207056	5.532270	0.268684	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/30/2015 9:44 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	735,466					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,887,509				14.00
15.00	01500	PHARMACY	0	125,704	2,825,079			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	394,772,696		16.00
17.00	01700	SOCIAL SERVICE	0	660	0	0	13,896	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	226,261	389,707	2,158	36,457,623	3,119	30.00
31.00	03100	INTENSIVE CARE UNIT	27,379	86,601	831	5,183,167	1,426	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	40,141	86,034	2,311	11,847,899	2,315	35.00
43.00	04300	NURSERY	30,296	0	0	6,744,829	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	118,719	8,078,275	201,173	120,451,859	273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,238	333,382	3,952	25,139,343	1,758	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	258,961	1,459	16,754,135	0	54.00
54.02	05402	ULTRASOUND	0	1,492	0	2,982,837	0	54.02
57.00	05700	CT SCAN	0	12,822	0	6,785,586	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,485	216	3,294,240	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	782	23,392	27,063,277	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	82,834	2,031	4,431,847	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,850	100	2,030,817	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	140,246	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	471	0	2,497,543	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,652	0	2,167,929	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,663,185	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,374,317	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,365,722	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	2,526,853	201,554	66,509,542	0	75.00
76.00	03330	ENDOSCOPY	33,358	513,066	9,672	22,204,318	728	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	47,866	262,880	4,717	32,085,659	3,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	578,258	18,827,013	2,819,288	394,772,696	13,167	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,047	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	357	0	0	729	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	10,131	0	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	147,077	57,092	5,791	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,573,303	1,162,579	7,533,188	1,303,678	419,431	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.498874	0.061553	2.666541	0.003302	30.183578	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	89,728	237,442	522,440	41,785	31,550	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.122002	0.012571	0.184929	0.000106	2.270438	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,732,909		20,732,909	0	20,732,909	30.00
31.00	03100	INTENSIVE CARE UNIT	3,173,772		3,173,772	0	3,173,772	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,301,498		3,301,498	0	3,301,498	35.00
43.00	04300	NURSERY	2,789,634		2,789,634	0	2,789,634	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,597,644		22,597,644	0	22,597,644	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,934,992		4,934,992	0	4,934,992	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,486,416		4,486,416	0	4,486,416	54.00
54.02	05402	ULTRASOUND	525,248		525,248	0	525,248	54.02
57.00	05700	CT SCAN	1,229,208		1,229,208	0	1,229,208	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,849,138		1,849,138	0	1,849,138	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,389,240		4,389,240	0	4,389,240	60.00
65.00	06500	RESPIRATORY THERAPY	2,151,868	0	2,151,868	0	2,151,868	65.00
66.00	06600	PHYSICAL THERAPY	574,622	0	574,622	0	574,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	42,582	0	42,582	0	42,582	68.00
69.00	06900	ELECTROCARDIOLOGY	453,480		453,480	0	453,480	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	177,143		177,143	0	177,143	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,140,464		2,140,464	0	2,140,464	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,629,601		5,629,601	0	5,629,601	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,340,612		6,340,612	0	6,340,612	73.00
75.00	07500	ASC (NON-DISTINCT PART)	13,333,336		13,333,336	0	13,333,336	75.00
76.00	03330	ENDOSCOPY	4,392,283		4,392,283	0	4,392,283	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,961,103		4,961,103	0	4,961,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,331,399		3,331,399		3,331,399	92.00
200.00		Subtotal (see instructions)	113,538,192	0	113,538,192	0	113,538,192	200.00
201.00		Less Observation Beds	3,331,399		3,331,399		3,331,399	201.00
202.00		Total (see instructions)	110,206,793	0	110,206,793	0	110,206,793	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/30/2015 9:44 am

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		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,361,544		28,361,544			30.00
31.00	03100	INTENSIVE CARE UNIT	5,183,167		5,183,167			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,847,899		11,847,899			35.00
43.00	04300	NURSERY	6,744,829		6,744,829			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,164,046	67,287,813	120,451,859	0.187607	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,460,923	678,420	25,139,343	0.196306	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,932,928	14,821,207	16,754,135	0.267780	0.000000	54.00
54.02	05402	ULTRASOUND	393,078	2,589,759	2,982,837	0.176090	0.000000	54.02
57.00	05700	CT SCAN	1,078,324	5,707,263	6,785,587	0.181150	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	170,627	3,123,613	3,294,240	0.561325	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	11,536,242	15,527,035	27,063,277	0.162184	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,959,680	1,472,167	4,431,847	0.485547	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,465,871	564,946	2,030,817	0.282951	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	89,121	51,125	140,246	0.303624	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	703,654	1,793,889	2,497,543	0.181570	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,683,714	484,215	2,167,929	0.081711	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,512,707	19,785,122	35,297,829	0.060640	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,451,267	3,258,350	20,709,617	0.271835	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,320,255	9,864,700	25,184,955	0.251762	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	66,509,542	66,509,542	0.200473	0.000000	75.00
76.00	03330	ENDOSCOPY	931,134	21,273,184	22,204,318	0.197812	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,640,739	27,444,920	32,085,659	0.154621	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	684,945	7,411,134	8,096,079	0.411483	0.000000	92.00
200.00		Subtotal (see instructions)	206,316,694	269,648,404	475,965,098			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	206,316,694	269,648,404	475,965,098			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

		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
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.187607	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.196306	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.267780	54.00
54.02	05402	ULTRASOUND	0.176090	54.02
57.00	05700	CT SCAN	0.181150	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.561325	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.162184	60.00
65.00	06500	RESPIRATORY THERAPY	0.485547	65.00
66.00	06600	PHYSICAL THERAPY	0.282951	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.303624	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181570	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081711	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.060640	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.271835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251762	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.200473	75.00
76.00	03330	ENDOSCOPY	0.197812	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.154621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411483	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: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/30/2015 9:44 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,732,909		20,732,909	0	20,732,909	30.00
31.00	03100	INTENSIVE CARE UNIT	3,173,772		3,173,772	0	3,173,772	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,301,498		3,301,498	0	3,301,498	35.00
43.00	04300	NURSERY	2,789,634		2,789,634	0	2,789,634	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,597,644		22,597,644	0	22,597,644	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,934,992		4,934,992	0	4,934,992	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,486,416		4,486,416	0	4,486,416	54.00
54.02	05402	ULTRASOUND	525,248		525,248	0	525,248	54.02
57.00	05700	CT SCAN	1,229,208		1,229,208	0	1,229,208	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,849,138		1,849,138	0	1,849,138	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,389,240		4,389,240	0	4,389,240	60.00
65.00	06500	RESPIRATORY THERAPY	2,151,868	0	2,151,868	0	2,151,868	65.00
66.00	06600	PHYSICAL THERAPY	574,622	0	574,622	0	574,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	42,582	0	42,582	0	42,582	68.00
69.00	06900	ELECTROCARDIOLOGY	453,480		453,480	0	453,480	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	177,143		177,143	0	177,143	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,140,464		2,140,464	0	2,140,464	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,629,601		5,629,601	0	5,629,601	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,340,612		6,340,612	0	6,340,612	73.00
75.00	07500	ASC (NON-DISTINCT PART)	13,333,336		13,333,336	0	13,333,336	75.00
76.00	03330	ENDOSCOPY	4,392,283		4,392,283	0	4,392,283	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,961,103		4,961,103	0	4,961,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,331,399		3,331,399		3,331,399	92.00
200.00		Subtotal (see instructions)	113,538,192	0	113,538,192	0	113,538,192	200.00
201.00		Less Observation Beds	3,331,399		3,331,399		3,331,399	201.00
202.00		Total (see instructions)	110,206,793	0	110,206,793	0	110,206,793	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/30/2015 9:44 am

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	28,361,544		28,361,544			30.00
31.00	03100	INTENSIVE CARE UNIT	5,183,167		5,183,167			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,847,899		11,847,899			35.00
43.00	04300	NURSERY	6,744,829		6,744,829			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	53,164,046	67,287,813	120,451,859	0.187607	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,460,923	678,420	25,139,343	0.196306	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,932,928	14,821,207	16,754,135	0.267780	0.000000	54.00
54.02	05402	ULTRASOUND	393,078	2,589,759	2,982,837	0.176090	0.000000	54.02
57.00	05700	CT SCAN	1,078,324	5,707,263	6,785,587	0.181150	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	170,627	3,123,613	3,294,240	0.561325	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	11,536,242	15,527,035	27,063,277	0.162184	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,959,680	1,472,167	4,431,847	0.485547	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,465,871	564,946	2,030,817	0.282951	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	89,121	51,125	140,246	0.303624	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	703,654	1,793,889	2,497,543	0.181570	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,683,714	484,215	2,167,929	0.081711	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,512,707	19,785,122	35,297,829	0.060640	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,451,267	3,258,350	20,709,617	0.271835	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,320,255	9,864,700	25,184,955	0.251762	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	66,509,542	66,509,542	0.200473	0.000000	75.00
76.00	03330	ENDOSCOPY	931,134	21,273,184	22,204,318	0.197812	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,640,739	27,444,920	32,085,659	0.154621	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	684,945	7,411,134	8,096,079	0.411483	0.000000	92.00
200.00		Subtotal (see instructions)	206,316,694	269,648,404	475,965,098			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	206,316,694	269,648,404	475,965,098			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/30/2015 9:44 am

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
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.02	05402	ULTRASOUND	0.000000	54.02
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
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	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.00	03330	ENDOSCOPY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part I | Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,909,295	0	2,909,295	13,673	212.78	30.00
31.00	INTENSIVE CARE UNIT	330,239		330,239	979	337.32	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	306,010		306,010	2,025	151.12	35.00
43.00	NURSERY	458,398		458,398	3,071	149.27	43.00
200.00	Total (lines 30-199)	4,003,942		4,003,942	19,748		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	3,575	760,689	30.00
31.00	INTENSIVE CARE UNIT	342	115,363	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0	35.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	3,917	876,052	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,697,070	120,451,859	0.022391	14,782,731	331,000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	573,002	25,139,343	0.022793	40,873	932	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,264	16,754,135	0.041438	554,460	22,976	54.00
54.02	05402	ULTRASOUND	93,574	2,982,837	0.031371	89,528	2,809	54.02
57.00	05700	CT SCAN	183,224	6,785,587	0.027002	464,950	12,555	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	589,223	3,294,240	0.178865	63,650	11,385	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	244,865	27,063,277	0.009048	3,446,868	31,187	60.00
65.00	06500	RESPIRATORY THERAPY	182,526	4,431,847	0.041185	950,797	39,159	65.00
66.00	06600	PHYSICAL THERAPY	70,925	2,030,817	0.034924	842,381	29,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,142	140,246	0.036664	52,988	1,943	68.00
69.00	06900	ELECTROCARDIOLOGY	39,767	2,497,543	0.015922	386,855	6,160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,725	2,167,929	0.010482	702,976	7,369	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,192	35,297,829	0.001875	3,854,224	7,227	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	174,090	20,709,617	0.008406	6,933,159	58,280	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	438,209	25,184,955	0.017400	4,194,106	72,977	73.00
75.00	07500	ASC (NON-DISTINCT PART)	951,055	66,509,542	0.014300	0	0	75.00
76.00	03330	ENDOSCOPY	483,686	22,204,318	0.021783	370,937	8,080	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	576,196	32,085,659	0.017958	2,059,746	36,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	467,472	8,096,079	0.057741	371,177	21,432	92.00
200.00		Total (lines 50-199)	8,553,207	423,827,659		40,162,406	701,879	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part III Date/Time Prepared: 11/30/2015 9:44 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0		0	35.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	13,673	0.00	3,575	0	30.00
31.00	03100	INTENSIVE CARE UNIT	979	0.00	342	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,025	0.00	0	0	35.00
43.00	04300	NURSERY	3,071	0.00	0	0	43.00
200.00		Total (lines 30-199)	19,748		3,917	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/30/2015 9:44 am

			Title XVIII		Hospital	PPS	
		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	120,451,859	0.000000	0.000000	14,782,731	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,139,343	0.000000	0.000000	40,873	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,754,135	0.000000	0.000000	554,460	54.00
54.02	05402	ULTRASOUND	0	2,982,837	0.000000	0.000000	89,528	54.02
57.00	05700	CT SCAN	0	6,785,587	0.000000	0.000000	464,950	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,294,240	0.000000	0.000000	63,650	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	27,063,277	0.000000	0.000000	3,446,868	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,431,847	0.000000	0.000000	950,797	65.00
66.00	06600	PHYSICAL THERAPY	0	2,030,817	0.000000	0.000000	842,381	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	140,246	0.000000	0.000000	52,988	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,497,543	0.000000	0.000000	386,855	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,167,929	0.000000	0.000000	702,976	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,297,829	0.000000	0.000000	3,854,224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,709,617	0.000000	0.000000	6,933,159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,184,955	0.000000	0.000000	4,194,106	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	66,509,542	0.000000	0.000000	0	75.00
76.00	03330	ENDOSCOPY	0	22,204,318	0.000000	0.000000	370,937	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	32,085,659	0.000000	0.000000	2,059,746	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,096,079	0.000000	0.000000	371,177	92.00
200.00		Total (lines 50-199)	0	423,827,659			40,162,406	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,724,878	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,473	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,345,459	0	54.00
54.02	05402	ULTRASOUND	0	302,018	0	54.02
57.00	05700	CT SCAN	0	1,478,971	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	749,440	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	3,490,396	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	286,192	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,813	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	530,922	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	60,135	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,512,622	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	557,932	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,716,434	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03330	ENDOSCOPY	0	2,145,013	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	5,321,309	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,639,581	0	92.00
200.00		Total (lines 50-199)	0	30,867,588	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.187607	8,724,878	0	0	1,636,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.196306	4,473	0	0	878	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.267780	1,345,459	2,836	0	360,287	54.00
54.02	05402	ULTRASOUND	0.176090	302,018	0	0	53,182	54.02
57.00	05700	CT SCAN	0.181150	1,478,971	0	0	267,916	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.561325	749,440	0	0	420,679	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.162184	3,490,396	0	0	566,086	60.00
65.00	06500	RESPIRATORY THERAPY	0.485547	286,192	0	0	138,960	65.00
66.00	06600	PHYSICAL THERAPY	0.282951	1,813	0	0	513	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.303624	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181570	530,922	0	0	96,400	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081711	60,135	0	0	4,914	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.060640	1,512,622	8	0	91,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.271835	557,932	0	0	151,665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251762	1,716,434	0	35,816	432,133	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.200473	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.197812	2,145,013	0	0	424,309	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.154621	5,321,309	0	0	822,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411483	2,639,581	0	0	1,086,143	92.00
200.00		Subtotal (see instructions)		30,867,588	2,844	35,816	6,555,424	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		30,867,588	2,844	35,816	6,555,424	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	759	0	54.00
54.02	05402	ULTRASOUND	0	0	54.02
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
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	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,017	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03330	ENDOSCOPY	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	759	9,017	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	759	9,017	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,673	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,673	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)	11,476	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,575	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	20,732,909	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	20,732,909	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	20,732,909	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,516.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,420,916	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)	5,420,916	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,173,772	979	3,241.85	342	1,108,713	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	NEONATAL INTENSIVE CARE UNIT	3,301,498	2,025	1,630.37	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,187,268	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,716,897	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)	876,052	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	701,879	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,577,931	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,138,966	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)	2,197	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,516.34	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,331,399	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/30/2015 9:44 am
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	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	2,909,295	20,732,909	0.140323	3,331,399	467,472	90.00
91.00	Nursing School cost	0	20,732,909	0.000000	3,331,399	0	91.00
92.00	Allied health cost	0	20,732,909	0.000000	3,331,399	0	92.00
93.00	All other Medical Education	0	20,732,909	0.000000	3,331,399	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/30/2015 9:44 am

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)	13,673	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,673	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)	11,476	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	389	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)	3,071	15.00
16.00	Nursery days (title V or XIX only)	187	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	20,732,909	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	20,732,909	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	20,732,909	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,516.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	589,856	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)	589,856	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/30/2015 9:44 am

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)	2,789,634	3,071	908.38	187	169,867	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,173,772	979	3,241.85	248	803,979	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	NEONATAL INTENSIVE CARE UNIT	3,301,498	2,025	1,630.37	293	477,698	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,510,529	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,551,929	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)	2,197	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,516.34	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,331,399	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/30/2015 9:44 am
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	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	2,909,295	20,732,909	0.140323	3,331,399	467,472	90.00
91.00	Nursing School cost	0	20,732,909	0.000000	3,331,399	0	91.00
92.00	Allied health cost	0	20,732,909	0.000000	3,331,399	0	92.00
93.00	All other Medical Education	0	20,732,909	0.000000	3,331,399	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,403,683		30.00
31.00	03100	INTENSIVE CARE UNIT		3,815,899		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0		35.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.187607	14,782,731	2,773,344	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.196306	40,873	8,024	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.267780	554,460	148,473	54.00
54.02	05402	ULTRASOUND	0.176090	89,528	15,765	54.02
57.00	05700	CT SCAN	0.181150	464,950	84,226	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.561325	63,650	35,728	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.162184	3,446,868	559,027	60.00
65.00	06500	RESPIRATORY THERAPY	0.485547	950,797	461,657	65.00
66.00	06600	PHYSICAL THERAPY	0.282951	842,381	238,353	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.303624	52,988	16,088	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181570	386,855	70,241	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081711	702,976	57,441	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.060640	3,854,224	233,720	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.271835	6,933,159	1,884,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251762	4,194,106	1,055,917	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.200473	0	0	75.00
76.00	03330	ENDOSCOPY	0.197812	370,937	73,376	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.154621	2,059,746	318,480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411483	371,177	152,733	92.00
200.00		Total (sum of lines 50-94 and 96-98)		40,162,406	8,187,268	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)		40,162,406		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 Date/Time Prepared: 11/30/2015 9:44 am

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		1,732,673		30.00
31.00	03100	INTENSIVE CARE UNIT		335,013		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		2,569,162		35.00
43.00	04300	NURSERY		530,095		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.187607	2,469,178	463,235	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.196306	2,063,603	405,098	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.267780	92,947	24,889	54.00
54.02	05402	ULTRASOUND	0.176090	35,911	6,324	54.02
57.00	05700	CT SCAN	0.181150	40,868	7,403	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.561325	9,087	5,101	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.162184	746,607	121,088	60.00
65.00	06500	RESPIRATORY THERAPY	0.485547	208,771	101,368	65.00
66.00	06600	PHYSICAL THERAPY	0.282951	33,998	9,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.303624	8,085	2,455	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181570	30,778	5,588	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081711	2,520	206	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.060640	1,365,852	82,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.271835	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251762	938,110	236,180	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.200473	0	0	75.00
76.00	03330	ENDOSCOPY	0.197812	46,744	9,247	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.154621	193,387	29,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.411483	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		8,286,446	1,510,529	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)		8,286,446		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A | Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,247,945			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		8,468,012			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0			1.04
2.00	Outlier payments for discharges. (see instructions)		74,219			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		146.98			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0			28.01
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/30/2015 9:44 am
	Title XVIII	Hospital	PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.31			30.00
31.00	Percentage of Medicaid patient days (see instructions)		12.56			31.00
32.00	Sum of lines 30 and 31		15.87			32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.07			33.00
34.00	Disproportionate share adjustment (see instructions)		82,245			34.00
			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000091381		0.000091381	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		826,671		698,849	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		208,367		522,701	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		731,068			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		1,094			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		11,603,489			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0			48.00
49.00	Total payment for inpatient operating costs (see instructions)		11,603,489			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		892,316			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		12,495,805			59.00
60.00	Primary payer payments		6,881			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,488,924			61.00
62.00	Deductibles billed to program beneficiaries		1,082,452			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/30/2015 9:44 am

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		18,698			63.00
64.00	Allowable bad debts (see instructions)		82,271			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		53,476			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		11,219			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,441,250			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00			0			70.00
70.01			0			70.01
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		30,291			70.93
70.94	HRR adjustment amount (see instructions)		-6,775			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,464,766			71.00
71.01	Sequestration adjustment (see instructions)		229,295			71.01
72.00	Interim payments		10,565,016			72.00
73.00	Tentative settlement (for contractor use only)		0			73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		670,455			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/30/2015 9:44 am

		Title XVIII	Hospital	PPS	
		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	0		0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0		0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150157

Period: From 07/01/2014 To 06/30/2015

Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/30/2015 9:44 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,247,945	0	2,247,945	0	2,247,945	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,468,012	0	0	8,468,012	8,468,012	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	74,219	0	27,541	46,678	74,219	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0307	0.0307	0.0307	0.0307		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	82,245	0	17,253	64,992	82,245	11.00
11.01	Uncompensated care payments	36.00	731,068	0	0	618,301	618,301	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,603,489	0	2,292,739	9,310,750	11,603,489	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,603,489	0	2,292,739	9,310,750	11,603,489	15.00
16.00	Payment for inpatient program capital	50.00	892,316	0	187,867	704,449	892,316	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/30/2015 9:44 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	2,480,606	10,015,199	12,495,805	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	857,013	0	179,682	677,331	857,013	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	7,364	0	2,327	5,037	7,364	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0326	0.0326	0.0326	0.0326		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	27,939	0	5,858	22,081	27,939	25.00
26.00	Total prospective capital payments (see instructions)	12.00	892,316	0	187,867	704,449	892,316	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/30/2015 9:44 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,247,945	2,247,945		2,247,945	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,468,012		8,468,012	8,468,012	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	74,219	27,541	46,678	74,219	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0307	0.0307	0.0307		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	82,245	17,253	64,992	82,245	11.00
11.01	Uncompensated care payments	36.00	731,068	208,366	618,301	826,667	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,603,489	2,501,105	9,102,384	11,603,489	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,603,489	2,501,105	9,102,384	11,603,489	15.00
16.00	Payment for inpatient program capital	50.00	892,316	187,867	704,449	892,316	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,688,972	9,806,833	12,495,805	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	857,013	179,682	677,331	857,013	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	7,364	2,327	5,037	7,364	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0326	0.0326	0.0326		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	27,939	5,858	22,081	27,939	25.00
26.00	Total prospective capital payments (see instructions)	12.00	892,316	187,867	704,449	892,316	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	30,291	-2,801	33,092	30,291	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-6,775	0	-6,775	-6,775	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/30/2015 9:44 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,776	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,555,424	2.00
3.00	PPS payments	5,028,826	3.00
4.00	Outlier payment (see instructions)	54,482	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)	9,776	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	38,660	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)	38,660	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)	38,660	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	28,884	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)	9,776	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	5,083,308	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	727	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,136,064	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,956,293	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,956,293	30.00
31.00	Primary payer payments	179	31.00
32.00	Subtotal (line 30 minus line 31)	3,956,114	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)	165,284	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	107,435	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	94,867	36.00
37.00	Subtotal (see instructions)	4,063,549	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,063,549	40.00
40.01	Sequestration adjustment (see instructions)	81,271	40.01
41.00	Interim payments	3,870,490	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	111,788	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: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 11/30/2015 9:44 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,565,016		3,870,490	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,565,016		3,870,490	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		670,455		111,788	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,235,471		3,982,278	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: 150157	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/30/2015 9:44 am
	Title XVIII	Hospital	PPS

		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	5,914	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,917	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,121	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	14,480	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	475,965,098	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	8,038,425	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)	522,534	8.00
9.00	Sequestration adjustment amount (see instructions)	10,451	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	512,083	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	546,523	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)	-34,440	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-3 Part VII Date/Time Prepared: 11/30/2015 9:44 am

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	3,551,929		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)	3,551,929	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)	3,551,929	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	3,490,863		8.00
9.00	Ancillary service charges	8,286,446	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)	11,777,309	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)	11,777,309	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,225,380	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)	3,551,929	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)	3,551,929	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)	3,551,929	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)	3,551,929	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	3,551,929	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)	3,551,929	0	40.00
41.00	Interim payments	3,551,929	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: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/30/2015 9:44 am

		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	5,745,065	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	49,102,241	0	0	0	4.00
5.00	Other receivable	3,584,861	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-22,955,977	0	0	0	6.00
7.00	Inventory	2,485,163	0	0	0	7.00
8.00	Prepaid expenses	119,583	0	0	0	8.00
9.00	Other current assets	470,261	0	0	0	9.00
10.00	Due from other funds	24,211,137	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	62,762,334	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,111,746	0	0	0	12.00
13.00	Land improvements	2,267,694	0	0	0	13.00
14.00	Accumulated depreciation	-2,126,736	0	0	0	14.00
15.00	Buildings	80,155,097	0	0	0	15.00
16.00	Accumulated depreciation	-40,518,621	0	0	0	16.00
17.00	Leasehold improvements	3,913,471	0	0	0	17.00
18.00	Accumulated depreciation	-1,812,528	0	0	0	18.00
19.00	Fixed equipment	12,533,777	0	0	0	19.00
20.00	Accumulated depreciation	-2,865,646	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	42,588,380	0	0	0	23.00
24.00	Accumulated depreciation	-27,795,183	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	68,451,451	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	607,053,388	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	30,467,412	215,135	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	637,520,800	215,135	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	768,734,585	215,135	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,545,165	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,854,238	0	0	0	38.00
39.00	Payroll taxes payable	273,204	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	25,417,500	0	0	0	43.00
44.00	Other current liabilities	6,649,865	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	39,739,972	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,479,572	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	20,479,572	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	60,219,544	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	708,515,041				52.00
53.00	Specific purpose fund		215,135			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)	708,515,041	215,135	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	768,734,585	215,135	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/30/2015 9:44 am

		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		711,236,924		217,241		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		55,405,949				2.00
3.00	Total (sum of line 1 and line 2)		766,642,873		217,241		3.00
4.00		0		0		0	4.00
5.00	OTHER ACTIVITY	0		0		0	5.00
6.00	GRANT REVENUE	0		0		0	6.00
7.00	RESTRICTED INCOME	0		0		0	7.00
8.00	RESTRICTED UNREALIZED GAIN	0		0		0	8.00
9.00	OTHER ADJUSTMENT	2,106		0		0	9.00
10.00	Total additions (sum of line 4-9)		2,106		0		10.00
11.00	Subtotal (line 3 plus line 10)		766,644,979		217,241		11.00
12.00	TRANSFER TO AFFLIATES	58,109,559		0		0	12.00
13.00	NET ASSETS RELEASED FROM RESTRICTION	20,380		0		0	13.00
14.00	OTHER ADJUSTMENT	0		2,106		0	14.00
15.00	OTHER ADJUSTMENT	0		0		0	15.00
16.00	ROUNDING	-1		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		58,129,938		2,106		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		708,515,041		215,135		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/30/2015 9:44 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	35,106,373		35,106,373	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)	35,106,373		35,106,373	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,183,167		5,183,167	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	NEONATAL INTENSIVE CARE UNIT	11,847,899		11,847,899	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	17,031,066		17,031,066	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	52,137,439		52,137,439	17.00
18.00	Ancillary services	150,517,640	242,203,483	392,721,123	18.00
19.00	Outpatient services	3,661,615	27,444,920	31,106,535	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	0	14,391,294	14,391,294	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	206,316,694	284,039,697	490,356,391	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		131,340,935		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)		131,340,935		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-3 | Date/Time Prepared: 11/30/2015 9:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	490,356,391	1.00
2.00	Less contractual allowances and discounts on patients' accounts	300,882,312	2.00
3.00	Net patient revenues (line 1 minus line 2)	189,474,079	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	131,340,935	4.00
5.00	Net income from service to patients (line 3 minus line 4)	58,133,144	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	18,372,015	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	513,283	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	322,825	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	680,142	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAIN ON INVESTMENTS	-24,313,499	24.00
24.01		0	24.01
24.02	MISCELLANEOUS REVENUE	656,270	24.02
24.03		0	24.03
24.04	INCOME FROM UNCONSOLIDATED ENTITIES	18,590	24.04
24.05	OTHER NONOPERATING	20,380	24.05
24.06	CONSOLIDATING AMT (BILLING ARRANGE)	1,501,251	24.06
24.07	GOVT CLNC INCENTIVE REV	537,117	24.07
24.08	STATE PROGRAM REVENUE	59,397	24.08
24.09	GAIN ON SALE OF PPE	49,623	24.09
25.00	Total other income (sum of lines 6-24)	-1,582,606	25.00
26.00	Total (line 5 plus line 25)	56,550,538	26.00
27.00	LOSS ON UNCONSOLIDATED ENTITIES	903,987	27.00
27.01	INTEREST RATE SWAP LOSS	2,015	27.01
27.02	RESTRUCTURING & NONRECURRING EXPENSE	27,887	27.02
27.03	DONATIONS	210,700	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,144,589	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	55,405,949	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 150157 | Period: From 07/01/2014 To 06/30/2015 | Worksheet L Parts I-III Date/Time Prepared: 11/30/2015 9:44 am

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	857,013	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	7,364	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	44.52	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.31	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	12.56	8.00
9.00	Sum of lines 7 and 8	15.87	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.26	10.00
11.00	Disproportionate share adjustment (see instructions)	27,939	11.00
12.00	Total prospective capital payments (see instructions)	892,316	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00