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: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/24/2015 10:55 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/24/2015 Time: 10:55 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 HEART CENTER (150153) 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 Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	178,835	44,634	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	178,835	44,634	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/24/2015 9:29 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 10580 N. MERIDIAN ST.	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	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 HEART CENTER	150153	26900	1	12/05/2002	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: 1.00	To: 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)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	298	0	0	0	425	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 9:29 am

		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.				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 9:29 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 9:29 am

		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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/24/2015 9:29 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)			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.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	103,994	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	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: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 9:29 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	15HO46	140.00

1.00	2.00	3.00

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 10330 N. MERIDIAN ST	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/24/2015 9:29 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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/24/2015 9:29 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)	Y			3.00

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

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

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

			Part A		Part B	
		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	10/15/2015	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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/24/2015 9:29 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				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 583-3232	JILL.HILL@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/24/2015 9:29 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)	10/15/2015			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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/24/2015 9:29 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	107	39,055	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)		107	39,055	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		107	39,055	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)		107				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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/24/2015 9:29 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)	11,098	298	19,419			1.00
2.00	HMO and other (see instructions)	2,417	425				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)	11,098	298	19,419			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	11,098	298	19,419	0.00	410.86	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	410.86	27.00
28.00	Observation Bed Days		0	2,169			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/24/2015 9:29 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	2,484	75	4,531	1.00
2.00	HMO and other (see instructions)			568	84		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,484	75	4,531	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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 11/24/2015 9:29 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	29,172,307	0	29,172,307	854,585.00	34.14	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		0	0	0	0.00	0.00	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)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		288,029	0	288,029	4,551.00	63.29	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		24,000	0	24,000	120.00	200.00	13.00
14.00	Home office salaries & wage-related costs		7,608,279	0	7,608,279	131,365.00	57.92	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)		8,538,874	0	8,538,874			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	812,305	0	812,305	7,348.00	110.55	26.00
27.00	Administrative & General	5.00	4,030,122	0	4,030,122	142,395.00	28.30	27.00
28.00	Administrative & General under contract (see inst.)		21,975	0	21,975	393.00	55.92	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	494,594	0	494,594	16,515.00	29.95	30.00
31.00	Laundry & Linen Service	8.00	34,217	0	34,217	2,807.00	12.19	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		687,685	0	687,685	31,878.00	21.57	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		428,243	0	428,243	16,612.00	25.78	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	1,121,937	0	1,121,937	25,957.00	43.22	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,631,287	0	1,631,287	37,248.00	43.80	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 11/24/2015 9:29 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	1,505,383	0	1,505,383	46,640.00	32.28	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 11/24/2015 9:29 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)		30,310,210	0	30,310,210	903,468.00	33.55	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		30,310,210	0	30,310,210	903,468.00	33.55	3.00
4.00	Subtotal other wages & related costs (see inst.)		7,920,308	0	7,920,308	136,036.00	58.22	4.00
5.00	Subtotal wage-related costs (see inst.)		8,538,874	0	8,538,874	0.00	28.17	5.00
6.00	Total (sum of lines 3 thru 5)		46,769,392	0	46,769,392	1,039,504.00	44.99	6.00
7.00	Total overhead cost (see instructions)		10,767,748	0	10,767,748	327,793.00	32.85	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 11/24/2015 9:29 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,328,839	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)	3,915,663	8.00
9.00	Prescription Drug Plan	711,845	9.00
10.00	Dental, Hearing and Vision Plan	46,635	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	18,372	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-382	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	263,821	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	5,572	14.00
15.00	'Workers' Compensation Insurance	189,731	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	2,033,222	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	3,003	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	22,551	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,538,872	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 11/24/2015 9:29 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	81,978	8,304,231	1.00
2.00	Hospital	81,978	8,304,231	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	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/24/2015 9:29 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)	0.231300	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	0	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	11,196,795	6.00
7.00	Medicaid cost (line 1 times line 6)	2,589,819	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)	2,589,819	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)	2,589,819	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	7,827,272	1,031,566	8,858,838	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,810,448	238,601	2,049,049	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)	1,810,448	238,601	2,049,049	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)	3,111,584	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	326,027	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,785,557	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	644,299	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,693,348	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,283,167	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/24/2015 9:29 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		2,345,174	2,345,174	1,323,523	3,668,697	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,153,348	3,153,348	359,085	3,512,433	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	812,305	8,778,610	9,590,915	0	9,590,915	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,030,122	17,848,601	21,878,723	-1,684,286	20,194,437	5.00
7.00	00700	OPERATION OF PLANT	494,594	3,409,728	3,904,322	-421	3,903,901	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,217	389,777	423,994	0	423,994	8.00
9.00	00900	HOUSEKEEPING	0	834,353	834,353	0	834,353	9.00
10.00	01000	DIETARY	0	1,761,935	1,761,935	-1,145,949	615,986	10.00
11.00	01100	CAFETERIA	0	0	0	1,145,331	1,145,331	11.00
13.00	01300	NURSING ADMINISTRATION	1,121,937	108,496	1,230,433	-177	1,230,256	13.00
15.00	01500	PHARMACY	1,631,287	34,847	1,666,134	0	1,666,134	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,505,383	527,972	2,033,355	0	2,033,355	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,186,501	1,640,998	12,827,499	-551,691	12,275,808	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,291,362	4,737,042	8,028,404	-2,799,307	5,229,097	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	581,241	382,072	963,313	-4,901	958,412	54.00
57.00	05700	CT SCAN	346,661	128,235	474,896	0	474,896	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,638	182,506	249,144	-89,994	159,150	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,504,586	836,118	2,340,704	-1,729,760	610,944	59.00
60.00	06000	LABORATORY	0	3,272,947	3,272,947	-324	3,272,623	60.00
65.00	06500	RESPIRATORY THERAPY	1,086,791	118,217	1,205,008	-53,558	1,151,450	65.00
66.00	06600	PHYSICAL THERAPY	318,845	9,472	328,317	-1,998	326,319	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	182,067	182,067	5,334,461	5,516,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,245,846	22,245,846	0	22,245,846	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,136,161	3,136,161	-60,831	3,075,330	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,159,837	886,458	2,046,295	-39,203	2,007,092	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,172,307	76,950,980	106,123,287	0	106,123,287	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	1,310,004	1,310,004	0	1,310,004	193.01
200.00		TOTAL (SUM OF LINES 118-199)	29,172,307	78,260,984	107,433,291	0	107,433,291	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/24/2015 9:29 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	-643,452	3,025,245		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-462,312	3,050,121		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-521,647	9,069,268		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,069,509	19,124,928		5.00
7.00	00700	OPERATION OF PLANT	-76	3,903,825		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	423,994		8.00
9.00	00900	HOUSEKEEPING	0	834,353		9.00
10.00	01000	DIETARY	0	615,986		10.00
11.00	01100	CAFETERIA	-449,043	696,288		11.00
13.00	01300	NURSING ADMINISTRATION	-565	1,229,691		13.00
15.00	01500	PHARMACY	-1,250	1,664,884		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,107	2,025,248		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,629	12,272,179		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-898,783	4,330,314		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-60,361	898,051		54.00
57.00	05700	CT SCAN	-39,695	435,201		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	159,150		58.00
59.00	05900	CARDIAC CATHETERIZATION	-1,689	609,255		59.00
60.00	06000	LABORATORY	0	3,272,623		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,151,450		65.00
66.00	06600	PHYSICAL THERAPY	0	326,319		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,516,528		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,245,846		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,075,330		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-795,961	1,211,131		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,956,079	101,167,208		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	1,323,269	2,633,273		193.01
200.00		TOTAL (SUM OF LINES 118-199)	-3,632,810	103,800,481		200.00

RECLASSIFICATIONS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/24/2015 9:29 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAPITAL				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,128,808	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	280,597	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	37,377	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,066	4.00
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	157,338	5.00
6.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	63,422	6.00
	TOTALS		0	1,682,608	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	0	1,145,331	1.00
	TOTALS		0	1,145,331	
	C - SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,334,461	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	5,334,461	
500.00	Grand Total: Increases		0	8,162,400	500.00

RECLASSIFICATIONS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/24/2015 9:29 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAPITAL						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,128,808	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	280,597	11		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	37,377	12		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	15,066	12		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	157,338	13		5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	0	63,422	13		6.00
	TOTALS		0	1,682,608			
	B - CAFETERIA						
1.00	DIETARY	10.00	0	1,145,331	0		1.00
	TOTALS		0	1,145,331			
	C - SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,678	0		1.00
2.00	OPERATION OF PLANT	7.00	0	421	0		2.00
3.00	DIETARY	10.00	0	618	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	177	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	551,691	0		5.00
6.00	OPERATING ROOM	50.00	0	2,799,307	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,901	0		7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	89,994	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	1,729,760	0		9.00
10.00	LABORATORY	60.00	0	324	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	53,558	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	1,998	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	60,831	0		13.00
14.00	EMERGENCY	91.00	0	39,203	0		14.00
	TOTALS		0	5,334,461			
500.00	Grand Total: Decreases		0	8,162,400			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/24/2015 9:29 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	43,816,123	0	0	0	2,323,957	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6,258,340	0	0	0	3,348,315	5.00
6.00	Movable Equipment	18,815,361	0	0	0	917,191	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,889,824	0	0	0	6,589,463	8.00
9.00	Reconciling Items	1,238,434	0	0	0	1,154,443	9.00
10.00	Total (line 8 minus line 9)	67,651,390	0	0	0	5,435,020	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	41,492,166	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2,910,025	0				5.00
6.00	Movable Equipment	17,898,170	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	62,300,361	0				8.00
9.00	Reconciling Items	83,991	0				9.00
10.00	Total (line 8 minus line 9)	62,216,370	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 11/24/2015 9:29 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	1,799,316	545,858	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,147,072	1,004,722	0	1,554	0	2.00
3.00	Total (sum of lines 1-2)	3,946,388	1,550,580	0	1,554	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,345,174		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,153,348		2.00
3.00	Total (sum of lines 1-2)	0	5,498,522		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/24/2015 9:29 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	44,402,191	0	44,402,191	0.712712	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,898,170	0	17,898,170	0.287288	0	2.00
3.00	Total (sum of lines 1-2)	62,300,361	0	62,300,361	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,799,316	571,437	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,779,761	1,004,722	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,579,077	1,576,159	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	459,777	37,377	157,338	0	3,025,245	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	185,596	16,620	63,422	0	3,050,121	2.00
3.00	Total (sum of lines 1-2)	645,373	53,997	220,760	0	6,075,366	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/24/2015 9:29 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)	B	-382,176	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-95,001	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-64,885	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	-1,794,473			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,440,927			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-449,043	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-8,092	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SPONSORSHIPS/DONATIONS	A	-26,449	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER NON-REIMBURSABLE EXPENSE	A	-155	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/24/2015 9:29 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	
33.02	LOSS ON SALE OF PPE	A	-367,311	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.02
33.03	LOBBYING DUES	A	-1,408	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PROVIDER ASSESSMENT TAX	A	-1,556,659	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISC INCOME	B	-565	NURSING ADMINISTRATION	13.00	0	33.05
33.06	MISC INCOME	B	-1,250	PHARMACY	15.00	0	33.06
33.07	MISC INCOME	B	29,832	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	INCENTIVE ACCRUAL	A	-342,446	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	ENTERTAINMENT	A	-1,125	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	ENTERTAINMENT	A	-6,871	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	ENTERTAINMENT	A	-15	MEDICAL RECORDS & LIBRARY	16.00	0	33.11
33.12	ENTERTAINMENT	A	-3,629	ADULTS & PEDIATRICS	30.00	0	33.12
33.13	ENTERTAINMENT	A	-327	OPERATING ROOM	50.00	0	33.13
33.14	ENTERTAINMENT	A	-1,689	CARDIAC CATHETERIZATION	59.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,632,810				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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/24/2015 9:29 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	CHARGEBACKS	1,077,178	1,077,178	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CHARGEBACKS	5,394,161	5,394,161	2.00
3.00	7.00	OPERATION OF PLANT	CHARGEBACKS	140,292	140,292	3.00
3.01	13.00	NURSING ADMINISTRATION	CHARGEBACKS	-22,684	-22,684	3.01
4.00	15.00	PHARMACY	CHARGEBACKS	7,752	7,752	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	CHARGEBACKS	1,544,394	1,544,394	4.01
4.02	30.00	ADULTS & PEDIATRICS	CHARGEBACKS	1,000	1,000	4.02
4.03	50.00	OPERATING ROOM	CHARGEBACKS	2,074,922	2,074,922	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	CHARGEBACKS	294,320	294,320	4.04
4.05	57.00	CT SCAN	CHARGEBACKS	92,580	92,580	4.05
4.06	58.00	MAGNETIC RESONANCE IMAGING (	CHARGEBACKS	175	175	4.06
4.07	59.00	CARDIAC CATHETERIZATION	CHARGEBACKS	-51,294	-51,294	4.07
4.08	65.00	RESPIRATORY THERAPY	CHARGEBACKS	60,940	60,940	4.08
4.09	66.00	PHYSICAL THERAPY	CHARGEBACKS	178,204	178,204	4.09
4.10	73.00	DRUGS CHARGED TO PATIENTS	CHARGEBACKS	150	150	4.10
4.11	91.00	EMERGENCY	CHARGEBACKS	-10,345	-10,345	4.11
4.12	193.01	MARKETING	CHARGEBACKS	1,310,004	1,310,004	4.12
4.13	1.00	CAP REL COSTS-BLDG & FIXT	CIHC NEWCO-RENT	25,579	0	4.13
4.14	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	1,178,139	1,178,139	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	3,785,562	3,963,638	4.15
4.16	7.00	OPERATION OF PLANT	TRIMEDX	1,911	1,987	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	571,322	0	4.17
4.18	193.01	MARKETING	HOME OFFICE	1,323,269	0	4.18
4.19	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	1,037,719	1,324,574	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	51,500	65,736	4.20
5.00	0		0	20,066,750	18,625,823	5.00

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

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

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

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

6.00	B		0.00	ST. VINCENT HOS	0.00	6.00
7.00	B		74.08	ST. VINCENT HEA	0.00	7.00
8.00	B		0.00	CIHS NEWCO	0.00	8.00
9.00	B		100.00	ASCENSION	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-1 Date/Time Prepared: 11/24/2015 9:29 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	0	9		1.00
2.00	0	9		2.00
3.00	0	0		3.00
3.01	0	0		3.01
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	25,579	10		4.13
4.14	0	0		4.14
4.15	-178,076	0		4.15
4.16	-76	0		4.16
4.17	571,322	0		4.17
4.18	1,323,269	0		4.18
4.19	-286,855	11		4.19
4.20	-14,236	0		4.20
5.00	1,440,927			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	HEALTH SVCS		6.00
7.00	HEALTH MGMT		7.00
8.00	PROPERTY MGMT		8.00
9.00	HEALTH MGMT		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/24/2015 9:29 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	50.00	OPERATING ROOM	893,456	893,456	0	0	0	1.00
2.00	50.00	OPERATING ROOM	5,000	5,000	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	60,361	60,361	0	0	0	3.00
4.00	57.00	CT SCAN	39,695	39,695	0	0	0	4.00
5.00	91.00	EMERGENCY	795,961	795,961	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,794,473	1,794,473	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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	57.00	CT SCAN	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	893,456		1.00
2.00	50.00	OPERATING ROOM	0	0	0	5,000		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	60,361		3.00
4.00	57.00	CT SCAN	0	0	0	39,695		4.00
5.00	91.00	EMERGENCY	0	0	0	795,961		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,794,473		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/24/2015 9:29 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,025,245	3,025,245				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,050,121		3,050,121			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,069,268	10,591	10,678	9,090,537		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,124,928	212,406	214,153	1,291,819	20,843,306	5.00
7.00	00700	OPERATION OF PLANT	3,903,825	535,505	539,908	158,538	5,137,776	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	423,994	40,266	40,597	10,968	515,825	8.00
9.00	00900	HOUSEKEEPING	834,353	85,532	86,236	0	1,006,121	9.00
10.00	01000	DIETARY	615,986	65,345	65,883	0	747,214	10.00
11.00	01100	CAFETERIA	696,288	64,217	64,745	0	825,250	11.00
13.00	01300	NURSING ADMINISTRATION	1,229,691	67,415	67,970	359,627	1,724,703	13.00
15.00	01500	PHARMACY	1,664,884	68,705	69,270	522,894	2,325,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,025,248	70,130	70,707	482,537	2,648,622	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,272,179	1,054,266	1,062,932	3,585,726	17,975,103	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,330,314	296,433	298,871	1,055,016	5,980,634	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	898,051	26,665	26,884	186,312	1,137,912	54.00
57.00	05700	CT SCAN	435,201	15,940	16,071	111,119	578,331	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,150	16,773	16,911	21,360	214,194	58.00
59.00	05900	CARDIAC CATHETERIZATION	609,255	168,538	169,924	482,282	1,429,999	59.00
60.00	06000	LABORATORY	3,272,623	38,277	38,592	0	3,349,492	60.00
65.00	06500	RESPIRATORY THERAPY	1,151,450	97,870	98,675	348,361	1,696,356	65.00
66.00	06600	PHYSICAL THERAPY	326,319	0	0	102,203	428,522	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,516,528	0	0	0	5,516,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,245,846	0	0	0	22,245,846	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,075,330	0	0	0	3,075,330	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,211,131	90,371	91,114	371,775	1,764,391	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)	101,167,208	3,025,245	3,050,121	9,090,537	101,167,208	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	2,633,273	0	0	0	2,633,273	193.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	103,800,481	3,025,245	3,050,121	9,090,537	103,800,481	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/24/2015 9:29 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	20,843,306					5.00
7.00	00700	OPERATION OF PLANT	1,290,887	6,428,663				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	129,603	114,199	759,627			8.00
9.00	00900	HOUSEKEEPING	252,792	242,577	0	1,501,490		9.00
10.00	01000	DIETARY	187,741	185,325	0	45,828	1,166,108	10.00
11.00	01100	CAFETERIA	207,347	182,123	0	45,036	0	11.00
13.00	01300	NURSING ADMINISTRATION	433,339	191,195	0	47,280	0	13.00
15.00	01500	PHARMACY	584,355	194,854	0	48,185	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	665,477	198,895	0	49,184	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,516,317	2,989,974	474,764	739,377	1,143,369	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,502,658	840,709	73,042	207,895	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	285,905	75,624	0	18,701	0	54.00
57.00	05700	CT SCAN	145,308	45,207	35,790	11,179	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	53,817	47,570	15,339	11,763	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	359,293	477,987	51,129	118,199	0	59.00
60.00	06000	LABORATORY	841,573	108,557	0	26,845	0	60.00
65.00	06500	RESPIRATORY THERAPY	426,216	277,568	36,521	68,639	522	65.00
66.00	06600	PHYSICAL THERAPY	107,668	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,386,050	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,589,341	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	772,689	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	443,310	256,299	73,042	63,379	22,217	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,181,686	6,428,663	759,627	1,501,490	1,166,108	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	661,620	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,843,306	6,428,663	759,627	1,501,490	1,166,108	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/24/2015 9:29 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		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	1,259,756					11.00
13.00	01300	NURSING ADMINISTRATION	47,664	2,444,181				13.00
15.00	01500	PHARMACY	68,449	138,028	3,359,624			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	85,709	172,831	0	3,820,718		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	665,876	1,342,740	0	693,923	30,541,443	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	131,610	265,391	0	407,024	9,408,963	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,415	61,332	0	156,994	1,766,883	54.00
57.00	05700	CT SCAN	19,961	40,251	0	31,854	907,881	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,972	5,992	0	12,260	363,907	58.00
59.00	05900	CARDIAC CATHETERIZATION	61,977	124,977	0	1,077,618	3,701,179	59.00
60.00	06000	LABORATORY	0	0	0	207,343	4,533,810	60.00
65.00	06500	RESPIRATORY THERAPY	63,824	128,701	0	83,727	2,782,074	65.00
66.00	06600	PHYSICAL THERAPY	16,091	32,447	0	15,165	599,893	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	265,478	7,168,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	505,788	28,340,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,359,624	291,304	7,498,947	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	65,208	131,491	0	72,240	2,891,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,259,756	2,444,181	3,359,624	3,820,718	100,505,588	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	3,294,893	193.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,259,756	2,444,181	3,359,624	3,820,718	103,800,481	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/24/2015 9:29 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30,541,443		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	9,408,963		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,766,883		54.00
57.00	05700	CT SCAN	0	907,881		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	363,907		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,701,179		59.00
60.00	06000	LABORATORY	0	4,533,810		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,782,074		65.00
66.00	06600	PHYSICAL THERAPY	0	599,893		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,168,056		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,340,975		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,498,947		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,891,577		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)	0	100,505,588		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	0	3,294,893		193.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	103,800,481		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/24/2015 9:29 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,591	10,678	21,269	21,269	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,533,406	212,406	214,153	1,959,965	3,023	5.00
7.00	00700	OPERATION OF PLANT	0	535,505	539,908	1,075,413	371	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,266	40,597	80,863	26	8.00
9.00	00900	HOUSEKEEPING	0	85,532	86,236	171,768	0	9.00
10.00	01000	DIETARY	0	65,345	65,883	131,228	0	10.00
11.00	01100	CAFETERIA	0	64,217	64,745	128,962	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	67,415	67,970	135,385	841	13.00
15.00	01500	PHARMACY	0	68,705	69,270	137,975	1,223	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	70,130	70,707	140,837	1,129	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,054,266	1,062,932	2,117,198	8,389	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	296,433	298,871	595,304	2,469	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,665	26,884	53,549	436	54.00
57.00	05700	CT SCAN	0	15,940	16,071	32,011	260	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,773	16,911	33,684	50	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	168,538	169,924	338,462	1,128	59.00
60.00	06000	LABORATORY	0	38,277	38,592	76,869	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	97,870	98,675	196,545	815	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	239	66.00
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
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	90,371	91,114	181,485	870	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)	1,533,406	3,025,245	3,050,121	7,608,772	21,269	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,533,406	3,025,245	3,050,121	7,608,772	21,269	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/24/2015 9:29 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	1,962,988					5.00
7.00	00700	OPERATION OF PLANT	121,575	1,197,359				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,206	21,270	114,365			8.00
9.00	00900	HOUSEKEEPING	23,808	45,181	0	240,757		9.00
10.00	01000	DIETARY	17,681	34,517	0	7,348	190,774	10.00
11.00	01100	CAFETERIA	19,528	33,921	0	7,221	0	11.00
13.00	01300	NURSING ADMINISTRATION	40,812	35,611	0	7,581	0	13.00
15.00	01500	PHARMACY	55,034	36,292	0	7,726	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,674	37,045	0	7,886	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	425,345	556,892	71,478	118,557	187,054	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	141,520	156,585	10,997	33,335	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,926	14,085	0	2,999	0	54.00
57.00	05700	CT SCAN	13,685	8,420	5,388	1,792	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,068	8,860	2,309	1,886	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	33,838	89,027	7,698	18,953	0	59.00
60.00	06000	LABORATORY	79,259	20,219	0	4,304	0	60.00
65.00	06500	RESPIRATORY THERAPY	40,141	51,698	5,498	11,006	85	65.00
66.00	06600	PHYSICAL THERAPY	10,140	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,538	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	526,376	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,772	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	41,751	47,736	10,997	10,163	3,635	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,900,677	1,197,359	114,365	240,757	190,774	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	62,311	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,962,988	1,197,359	114,365	240,757	190,774	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/24/2015 9:29 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		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	189,632					11.00
13.00	01300	NURSING ADMINISTRATION	7,175	227,405				13.00
15.00	01500	PHARMACY	10,304	12,842	261,396			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,902	16,080	0	278,553		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	100,236	124,928	0	50,586	3,760,663	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,811	24,692	0	29,672	1,014,385	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,578	5,706	0	11,445	119,724	54.00
57.00	05700	CT SCAN	3,005	3,745	0	2,322	70,628	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	447	557	0	894	53,755	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,329	11,628	0	78,583	588,646	59.00
60.00	06000	LABORATORY	0	0	0	15,115	195,766	60.00
65.00	06500	RESPIRATORY THERAPY	9,607	11,974	0	6,104	333,473	65.00
66.00	06600	PHYSICAL THERAPY	2,422	3,019	0	1,106	16,926	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	19,353	149,891	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,871	563,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	261,396	21,236	355,404	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,816	12,234	0	5,266	323,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	189,632	227,405	261,396	278,553	7,546,461	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	62,311	193.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	189,632	227,405	261,396	278,553	7,608,772	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/24/2015 9:29 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,760,663		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,014,385		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	119,724		54.00
57.00	05700	CT SCAN	0	70,628		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	53,755		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	588,646		59.00
60.00	06000	LABORATORY	0	195,766		60.00
65.00	06500	RESPIRATORY THERAPY	0	333,473		65.00
66.00	06600	PHYSICAL THERAPY	0	16,926		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	149,891		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	563,247		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	355,404		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	323,953		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)	0	7,546,461		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	0	62,311		193.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	7,608,772		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/24/2015 9:29 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	112,546					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		112,546				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	394	394	28,360,002			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,902	7,902	4,030,122	-20,843,306	82,957,175	5.00
7.00	00700	OPERATION OF PLANT	19,922	19,922	494,594	0	5,137,776	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,498	1,498	34,217	0	515,825	8.00
9.00	00900	HOUSEKEEPING	3,182	3,182	0	0	1,006,121	9.00
10.00	01000	DIETARY	2,431	2,431	0	0	747,214	10.00
11.00	01100	CAFETERIA	2,389	2,389	0	0	825,250	11.00
13.00	01300	NURSING ADMINISTRATION	2,508	2,508	1,121,937	0	1,724,703	13.00
15.00	01500	PHARMACY	2,556	2,556	1,631,287	0	2,325,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,609	2,609	1,505,383	0	2,648,622	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,221	39,221	11,186,501	0	17,975,103	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,028	11,028	3,291,362	0	5,980,634	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	992	992	581,241	0	1,137,912	54.00
57.00	05700	CT SCAN	593	593	346,661	0	578,331	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	624	624	66,638	0	214,194	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,270	6,270	1,504,586	0	1,429,999	59.00
60.00	06000	LABORATORY	1,424	1,424	0	0	3,349,492	60.00
65.00	06500	RESPIRATORY THERAPY	3,641	3,641	1,086,791	0	1,696,356	65.00
66.00	06600	PHYSICAL THERAPY	0	0	318,845	0	428,522	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,516,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	22,245,846	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,075,330	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,362	3,362	1,159,837	0	1,764,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	112,546	112,546	28,360,002	-20,843,306	80,323,902	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	2,633,273	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,025,245	3,050,121	9,090,537		20,843,306	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.880076	27.101105	0.320541		0.251254	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			21,269		1,962,988	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000750		0.023663	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/24/2015 9:29 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	84,328					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,498	567,483				8.00
9.00	00900	HOUSEKEEPING	3,182	0	79,648			9.00
10.00	01000	DIETARY	2,431	0	2,431	40,206		10.00
11.00	01100	CAFETERIA	2,389	0	2,389	0	685,520	11.00
13.00	01300	NURSING ADMINISTRATION	2,508	0	2,508	0	25,937	13.00
15.00	01500	PHARMACY	2,556	0	2,556	0	37,248	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,609	0	2,609	0	46,640	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,221	354,676	39,221	39,422	362,350	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,028	54,566	11,028	0	71,618	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	992	0	992	0	16,551	54.00
57.00	05700	CT SCAN	593	26,737	593	0	10,862	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	624	11,459	624	0	1,617	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,270	38,196	6,270	0	33,726	59.00
60.00	06000	LABORATORY	1,424	0	1,424	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,641	27,283	3,641	18	34,731	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	8,756	66.00
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
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,362	54,566	3,362	766	35,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	84,328	567,483	79,648	40,206	685,520	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,428,663	759,627	1,501,490	1,166,108	1,259,756	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	76.234027	1.338590	18.851572	29.003333	1.837665	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,197,359	114,365	240,757	190,774	189,632	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.198831	0.201530	3.022763	4.744914	0.276625	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/24/2015 9:29 am

		Cost Center Description	NURSING ADMINISTRATION (HOURS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	659,583				13.00
15.00	01500	PHARMACY	37,248	1,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,640	0	434,525,043		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	362,350	0	78,917,705		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	71,618	0	46,289,598		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,551	0	17,854,479		54.00
57.00	05700	CT SCAN	10,862	0	3,622,621		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,617	0	1,394,330		58.00
59.00	05900	CARDIAC CATHETERIZATION	33,726	0	122,560,907		59.00
60.00	06000	LABORATORY	0	0	23,580,449		60.00
65.00	06500	RESPIRATORY THERAPY	34,731	0	9,522,038		65.00
66.00	06600	PHYSICAL THERAPY	8,756	0	1,724,657		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	30,191,921		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	57,521,666		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,000	33,129,037		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	35,484	0	8,215,635		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	659,583	1,000	434,525,043		118.00
		NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MARKETING	0	0	0		193.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,444,181	3,359,624	3,820,718		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.705646	3,359.624000	0.008793		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	227,405	261,396	278,553		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.344771	261.396000	0.000641		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 9:29 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,541,443		30,541,443	0	30,541,443	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,408,963		9,408,963	0	9,408,963	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,766,883		1,766,883	0	1,766,883	54.00
57.00	05700	CT SCAN	907,881		907,881	0	907,881	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	363,907		363,907	0	363,907	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,701,179		3,701,179	0	3,701,179	59.00
60.00	06000	LABORATORY	4,533,810		4,533,810	0	4,533,810	60.00
65.00	06500	RESPIRATORY THERAPY	2,782,074	0	2,782,074	0	2,782,074	65.00
66.00	06600	PHYSICAL THERAPY	599,893	0	599,893	0	599,893	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,168,056		7,168,056	0	7,168,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,340,975		28,340,975	0	28,340,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,498,947		7,498,947	0	7,498,947	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,891,577		2,891,577	0	2,891,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,068,571		3,068,571		3,068,571	92.00
200.00		Subtotal (see instructions)	103,574,159	0	103,574,159	0	103,574,159	200.00
201.00		Less Observation Beds	3,068,571		3,068,571		3,068,571	201.00
202.00		Total (see instructions)	100,505,588	0	100,505,588	0	100,505,588	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 9:29 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	76,289,155		76,289,155			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,520,065	769,533	46,289,598	0.203263	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,722,001	5,132,478	17,854,479	0.098960	0.000000	54.00
57.00	05700	CT SCAN	708,107	2,914,514	3,622,621	0.250614	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	324,189	1,070,141	1,394,330	0.260991	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	79,431,454	43,129,453	122,560,907	0.030199	0.000000	59.00
60.00	06000	LABORATORY	19,292,434	4,288,015	23,580,449	0.192270	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,489,374	3,032,664	9,522,038	0.292172	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,644,338	80,319	1,724,657	0.347833	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,243,675	7,948,246	30,191,921	0.237416	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,756,559	24,765,107	57,521,666	0.492701	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,845,885	3,283,152	33,129,037	0.226356	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,566,821	5,648,814	8,215,635	0.351960	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,628,550	2,628,550	1.167401	0.000000	92.00
200.00		Subtotal (see instructions)	329,834,057	104,690,986	434,525,043			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	329,834,057	104,690,986	434,525,043			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 9:29 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.203263		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098960		54.00
57.00	05700	CT SCAN	0.250614		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.260991		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.030199		59.00
60.00	06000	LABORATORY	0.192270		60.00
65.00	06500	RESPIRATORY THERAPY	0.292172		65.00
66.00	06600	PHYSICAL THERAPY	0.347833		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237416		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.492701		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226356		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.351960		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.167401		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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,541,443		30,541,443	0	30,541,443	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,408,963		9,408,963	0	9,408,963	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,766,883		1,766,883	0	1,766,883	54.00
57.00	05700	CT SCAN	907,881		907,881	0	907,881	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	363,907		363,907	0	363,907	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,701,179		3,701,179	0	3,701,179	59.00
60.00	06000	LABORATORY	4,533,810		4,533,810	0	4,533,810	60.00
65.00	06500	RESPIRATORY THERAPY	2,782,074	0	2,782,074	0	2,782,074	65.00
66.00	06600	PHYSICAL THERAPY	599,893	0	599,893	0	599,893	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,168,056		7,168,056	0	7,168,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,340,975		28,340,975	0	28,340,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,498,947		7,498,947	0	7,498,947	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,891,577		2,891,577	0	2,891,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,068,571		3,068,571		3,068,571	92.00
200.00		Subtotal (see instructions)	103,574,159	0	103,574,159	0	103,574,159	200.00
201.00		Less Observation Beds	3,068,571		3,068,571		3,068,571	201.00
202.00		Total (see instructions)	100,505,588	0	100,505,588	0	100,505,588	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	76,289,155		76,289,155			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,520,065	769,533	46,289,598	0.203263	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,722,001	5,132,478	17,854,479	0.098960	0.000000	54.00
57.00	05700	CT SCAN	708,107	2,914,514	3,622,621	0.250614	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	324,189	1,070,141	1,394,330	0.260991	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	79,431,454	43,129,453	122,560,907	0.030199	0.000000	59.00
60.00	06000	LABORATORY	19,292,434	4,288,015	23,580,449	0.192270	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,489,374	3,032,664	9,522,038	0.292172	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,644,338	80,319	1,724,657	0.347833	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,243,675	7,948,246	30,191,921	0.237416	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,756,559	24,765,107	57,521,666	0.492701	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,845,885	3,283,152	33,129,037	0.226356	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,566,821	5,648,814	8,215,635	0.351960	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,628,550	2,628,550	1.167401	0.000000	92.00
200.00		Subtotal (see instructions)	329,834,057	104,690,986	434,525,043			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	329,834,057	104,690,986	434,525,043			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/24/2015 9:29 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
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
		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

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

Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part II Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,408,963	1,014,385	8,394,578	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,766,883	119,724	1,647,159	0	0	54.00
57.00	05700	CT SCAN	907,881	70,628	837,253	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	363,907	53,755	310,152	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,701,179	588,646	3,112,533	0	0	59.00
60.00	06000	LABORATORY	4,533,810	195,766	4,338,044	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,782,074	333,473	2,448,601	0	0	65.00
66.00	06600	PHYSICAL THERAPY	599,893	16,926	582,967	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,168,056	149,891	7,018,165	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,340,975	563,247	27,777,728	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,498,947	355,404	7,143,543	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,891,577	323,953	2,567,624	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,068,571	377,842	2,690,729	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	73,032,716	4,163,640	68,869,076	0	0	200.00
201.00		Less Observation Beds	3,068,571	377,842	2,690,729	0	0	201.00
202.00		Total (line 200 minus line 201)	69,964,145	3,785,798	66,178,347	0	0	202.00

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

Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part II Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,408,963	46,289,598	0.203263		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,766,883	17,854,479	0.098960		54.00
57.00	05700	CT SCAN	907,881	3,622,621	0.250614		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	363,907	1,394,330	0.260991		58.00
59.00	05900	CARDIAC CATHETERIZATION	3,701,179	122,560,907	0.030199		59.00
60.00	06000	LABORATORY	4,533,810	23,580,449	0.192270		60.00
65.00	06500	RESPIRATORY THERAPY	2,782,074	9,522,038	0.292172		65.00
66.00	06600	PHYSICAL THERAPY	599,893	1,724,657	0.347833		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,168,056	30,191,921	0.237416		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,340,975	57,521,666	0.492701		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,498,947	33,129,037	0.226356		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,891,577	8,215,635	0.351960		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,068,571	2,628,550	1.167401		92.00
200.00		Subtotal (sum of lines 50 thru 199)	73,032,716	358,235,888			200.00
201.00		Less Observation Beds	3,068,571	0			201.00
202.00		Total (line 200 minus line 201)	69,964,145	358,235,888			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part I Date/Time Prepared: 11/24/2015 9:29 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	3,760,663	0	3,760,663	21,588	174.20	30.00
200.00	Total (lines 30-199)	3,760,663		3,760,663	21,588		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	11,098	1,933,272				30.00
200.00	Total (lines 30-199)	11,098	1,933,272				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/24/2015 9:29 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	1,014,385	46,289,598	0.021914	21,089,882	462,164	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,724	17,854,479	0.006706	4,931,871	33,073	54.00
57.00	05700	CT SCAN	70,628	3,622,621	0.019496	432,650	8,435	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	53,755	1,394,330	0.038553	120,650	4,651	58.00
59.00	05900	CARDIAC CATHETERIZATION	588,646	122,560,907	0.004803	42,329,753	203,310	59.00
60.00	06000	LABORATORY	195,766	23,580,449	0.008302	13,395,676	111,211	60.00
65.00	06500	RESPIRATORY THERAPY	333,473	9,522,038	0.035021	3,333,903	116,757	65.00
66.00	06600	PHYSICAL THERAPY	16,926	1,724,657	0.009814	1,052,435	10,329	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149,891	30,191,921	0.004965	13,721,091	68,125	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	563,247	57,521,666	0.009792	28,499,075	279,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	355,404	33,129,037	0.010728	15,826,932	169,791	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	323,953	8,215,635	0.039431	1,518,282	59,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	377,842	2,628,550	0.143745	0	0	92.00
200.00		Total (lines 50-199)	4,163,640	358,235,888		146,252,200	1,526,776	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part III Date/Time Prepared: 11/24/2015 9:29 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
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,588	0.00	11,098	0		30.00
200.00		Total (lines 30-199)	21,588		11,098	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/24/2015 9:29 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
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
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
		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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/24/2015 9:29 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	46,289,598	0.000000	0.000000	21,089,882	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,854,479	0.000000	0.000000	4,931,871	54.00
57.00	05700	CT SCAN	0	3,622,621	0.000000	0.000000	432,650	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,394,330	0.000000	0.000000	120,650	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	122,560,907	0.000000	0.000000	42,329,753	59.00
60.00	06000	LABORATORY	0	23,580,449	0.000000	0.000000	13,395,676	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,522,038	0.000000	0.000000	3,333,903	65.00
66.00	06600	PHYSICAL THERAPY	0	1,724,657	0.000000	0.000000	1,052,435	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,191,921	0.000000	0.000000	13,721,091	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	57,521,666	0.000000	0.000000	28,499,075	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,129,037	0.000000	0.000000	15,826,932	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	8,215,635	0.000000	0.000000	1,518,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,628,550	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	358,235,888			146,252,200	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/24/2015 9:29 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	682,156	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,729,902	0		54.00
57.00	05700	CT SCAN	0	1,237,654	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	244,150	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	27,663,662	0		59.00
60.00	06000	LABORATORY	0	1,857,635	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	53,129	0		65.00
66.00	06600	PHYSICAL THERAPY	0	33,599	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,356,284	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,803,248	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,445,191	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	2,280,641	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,614,166	0		92.00
200.00		Total (lines 50-199)	0	52,001,417	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/24/2015 9:29 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	0.203263	682,156	0	0	138,657	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098960	1,729,902	0	0	171,191	54.00
57.00	05700	CT SCAN	0.250614	1,237,654	0	0	310,173	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.260991	244,150	0	0	63,721	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.030199	27,663,662	0	0	835,415	59.00
60.00	06000	LABORATORY	0.192270	1,857,635	0	0	357,167	60.00
65.00	06500	RESPIRATORY THERAPY	0.292172	53,129	0	0	15,523	65.00
66.00	06600	PHYSICAL THERAPY	0.347833	33,599	0	0	11,687	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237416	2,356,284	0	0	559,420	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.492701	10,803,248	0	0	5,322,771	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226356	1,445,191	0	28,143	327,128	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.351960	2,280,641	0	0	802,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.167401	1,614,166	0	0	1,884,379	92.00
200.00		Subtotal (see instructions)		52,001,417	0	28,143	10,799,926	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		52,001,417	0	28,143	10,799,926	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/24/2015 9:29 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
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	6,370		73.00
		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)	0	6,370		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	6,370		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part I Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,760,663	0	3,760,663	21,588	174.20	30.00
200.00	Total (lines 30-199)	3,760,663		3,760,663	21,588		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	298	51,912				30.00
200.00	Total (lines 30-199)	298	51,912				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,014,385	46,289,598	0.021914	1,188,771	26,051	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,724	17,854,479	0.006706	344,665	2,311	54.00
57.00	05700	CT SCAN	70,628	3,622,621	0.019496	18,036	352	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	53,755	1,394,330	0.038553	18,027	695	58.00
59.00	05900	CARDIAC CATHETERIZATION	588,646	122,560,907	0.004803	3,273,437	15,722	59.00
60.00	06000	LABORATORY	195,766	23,580,449	0.008302	481,707	3,999	60.00
65.00	06500	RESPIRATORY THERAPY	333,473	9,522,038	0.035021	328,411	11,501	65.00
66.00	06600	PHYSICAL THERAPY	16,926	1,724,657	0.009814	44,217	434	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149,891	30,191,921	0.004965	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	563,247	57,521,666	0.009792	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	355,404	33,129,037	0.010728	892,842	9,578	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	323,953	8,215,635	0.039431	45,027	1,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	377,842	2,628,550	0.143745	0	0	92.00
200.00		Total (lines 50-199)	4,163,640	358,235,888		6,635,140	72,418	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part III Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,588	0.00	298	0		30.00
200.00		Total (lines 30-199)	21,588		298	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
		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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	46,289,598	0.000000	0.000000	1,188,771	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,854,479	0.000000	0.000000	344,665	54.00
57.00	05700	CT SCAN	0	3,622,621	0.000000	0.000000	18,036	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,394,330	0.000000	0.000000	18,027	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	122,560,907	0.000000	0.000000	3,273,437	59.00
60.00	06000	LABORATORY	0	23,580,449	0.000000	0.000000	481,707	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,522,038	0.000000	0.000000	328,411	65.00
66.00	06600	PHYSICAL THERAPY	0	1,724,657	0.000000	0.000000	44,217	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,191,921	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	57,521,666	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,129,037	0.000000	0.000000	892,842	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	8,215,635	0.000000	0.000000	45,027	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,628,550	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	358,235,888			6,635,140	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	68,765	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	113,512	0		54.00
57.00	05700	CT SCAN	0	20,023	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	29,359	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,687,237	0		59.00
60.00	06000	LABORATORY	0	96,996	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	65,098	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,218	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	97,797	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	85,525	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	2,265,530	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.203263	68,765	0	0	13,977	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098960	113,512	0	0	11,233	54.00
57.00	05700	CT SCAN	0.250614	20,023	0	0	5,018	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.260991	29,359	0	0	7,662	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.030199	1,687,237	0	0	50,953	59.00
60.00	06000	LABORATORY	0.192270	96,996	0	0	18,649	60.00
65.00	06500	RESPIRATORY THERAPY	0.292172	65,098	0	0	19,020	65.00
66.00	06600	PHYSICAL THERAPY	0.347833	1,218	0	0	424	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237416	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.492701	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226356	97,797	0	0	22,137	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.351960	85,525	0	0	30,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.167401	0	0	0	0	92.00
200.00		Subtotal (see instructions)		2,265,530	0	0	179,174	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,265,530	0	0	179,174	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/24/2015 9:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/24/2015 9:29 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)	21,588	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,588	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)	19,419	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)	11,098	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)	30,541,443	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)	30,541,443	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)	30,541,443	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)	1,414.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	15,700,785	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)	15,700,785	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/24/2015 9:29 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	31,524,842	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	47,225,627	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)	1,933,272	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,526,776	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,460,048	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	43,765,579	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)	2,169	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,414.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,068,571	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/24/2015 9:29 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	3,760,663	30,541,443	0.123133	3,068,571	377,842	90.00
91.00	Nursing School cost	0	30,541,443	0.000000	3,068,571	0	91.00
92.00	Allied health cost	0	30,541,443	0.000000	3,068,571	0	92.00
93.00	All other Medical Education	0	30,541,443	0.000000	3,068,571	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/24/2015 9:29 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)	21,588	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,588	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)	19,419	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)	298	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)	30,541,443	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)	30,541,443	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)	30,541,443	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)	1,414.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	421,593	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)	421,593	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/24/2015 9:29 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	805,719	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,227,312	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)	2,169	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,414.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,068,571	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/24/2015 9:29 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	3,760,663	30,541,443	0.123133	3,068,571	377,842	90.00
91.00	Nursing School cost	0	30,541,443	0.000000	3,068,571	0	91.00
92.00	Allied health cost	0	30,541,443	0.000000	3,068,571	0	92.00
93.00	All other Medical Education	0	30,541,443	0.000000	3,068,571	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/24/2015 9:29 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		39,114,821		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.203263	21,089,882	4,286,793	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098960	4,931,871	488,058	54.00
57.00	05700	CT SCAN	0.250614	432,650	108,428	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.260991	120,650	31,489	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.030199	42,329,753	1,278,316	59.00
60.00	06000	LABORATORY	0.192270	13,395,676	2,575,587	60.00
65.00	06500	RESPIRATORY THERAPY	0.292172	3,333,903	974,073	65.00
66.00	06600	PHYSICAL THERAPY	0.347833	1,052,435	366,072	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237416	13,721,091	3,257,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.492701	28,499,075	14,041,523	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226356	15,826,932	3,582,521	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.351960	1,518,282	534,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.167401	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		146,252,200	31,524,842	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)		146,252,200		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/24/2015 9:29 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		2,157,474		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.203263	1,188,771	241,633	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098960	344,665	34,108	54.00
57.00	05700	CT SCAN	0.250614	18,036	4,520	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.260991	18,027	4,705	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.030199	3,273,437	98,855	59.00
60.00	06000	LABORATORY	0.192270	481,707	92,618	60.00
65.00	06500	RESPIRATORY THERAPY	0.292172	328,411	95,952	65.00
66.00	06600	PHYSICAL THERAPY	0.347833	44,217	15,380	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237416	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.492701	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226356	892,842	202,100	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.351960	45,027	15,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.167401	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		6,635,140	805,719	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)		6,635,140		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/24/2015 9:29 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)		8,520,746			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		28,464,573			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)		433,254			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)		101.06			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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/24/2015 9:29 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)		1.68			30.00
31.00	Percentage of Medicaid patient days (see instructions)		3.72			31.00
32.00	Sum of lines 30 and 31		5.40			32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00			33.00
34.00	Disproportionate share adjustment (see instructions)		0			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)		0.000024650		0.000026449	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
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)		37,418,573			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)		37,418,573			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,031,248			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		72,702			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)		40,522,523			59.00
60.00	Primary payer payments		1,830			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		40,520,693			61.00
62.00	Deductibles billed to program beneficiaries		2,228,164			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/24/2015 9:29 am

Title XVIII | Hospital | PPS

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		14,735			63.00
64.00	Allowable bad debts (see instructions)		277,287			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		180,237			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,489			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		38,458,031			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	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
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)		194,959			70.93
70.94	HRR adjustment amount (see instructions)		0			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)		38,652,990			71.00
71.01	Sequestration adjustment (see instructions)		773,060			71.01
72.00	Interim payments		37,701,095			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)		178,835			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: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/24/2015 9:29 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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/24/2015 9:29 am

Title XVIII | Hospital | PPS

		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	8,520,746	0	8,520,746	0	8,520,746	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	28,464,573	0	0	28,464,573	28,464,573	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	433,254	0	137,811	295,444	433,255	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	37,418,573	0	8,658,557	28,760,016	37,418,573	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	37,418,573	0	8,658,557	28,760,016	37,418,573	15.00
16.00	Payment for inpatient program capital	50.00	3,031,248	0	700,494	2,330,754	3,031,248	16.00
17.00	Special add-on payments for new technologies	54.00	72,702	0	0	72,702	72,702	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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/24/2015 9:29 am

Title XVIII | Hospital | PPS

		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	9,359,051	31,163,472	40,522,523	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	2,957,949	0	681,078	2,276,872	2,957,950	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	40,762	0	11,924	28,838	40,762	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	0.0110	0.0110	0.0110	0.0110		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	32,537	0	7,492	25,045	32,537	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,031,248	0	700,494	2,330,754	3,031,248	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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/24/2015 9:29 am

Title XVIII | Hospital | PPS

		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	8,520,746	8,520,746		8,520,746	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	28,464,573		28,464,573	28,464,573	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	433,254	137,811	295,444	433,255	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	37,418,573	8,658,557	28,760,016	37,418,573	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	37,418,573	8,658,557	28,760,016	37,418,573	15.00
16.00	Payment for inpatient program capital	50.00	3,031,248	700,494	2,330,754	3,031,248	16.00
17.00	Special add-on payments for new technologies	54.00	72,702	0	72,702	72,702	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			9,359,051	31,163,472	40,522,523	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/24/2015 9:29 am

Title XVIII | Hospital | PPS

		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	2,957,949	681,078	2,276,871	2,957,949	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	40,762	11,924	28,838	40,762	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	0.0110	0.0110	0.0110		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	32,537	7,492	25,045	32,537	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,031,248	700,494	2,330,754	3,031,248	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	194,959	38,770	156,189	194,959	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	0	672	-672	0	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: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/24/2015 9:29 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,370	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,799,926	2.00
3.00	PPS payments	12,969,166	3.00
4.00	Outlier payment (see instructions)	37,430	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)	6,370	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	28,143	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)	28,143	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)	28,143	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	21,773	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)	6,370	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)	13,006,596	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,775,816	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)	11,237,150	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)	11,237,150	30.00
31.00	Primary payer payments	276	31.00
32.00	Subtotal (line 30 minus line 31)	11,236,874	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)	224,292	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	145,790	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	100,709	36.00
37.00	Subtotal (see instructions)	11,382,664	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)	11,382,664	40.00
40.01	Sequestration adjustment (see instructions)	227,653	40.01
41.00	Interim payments	11,110,377	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	44,634	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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 11/24/2015 9:29 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		37,701,095		11,009,508	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	06/30/2015	100,869	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		100,869	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)		37,701,095		11,110,377	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		178,835		44,634	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		37,879,930		11,155,011	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/24/2015 9:29 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	1,227,312		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)	1,227,312	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)	1,227,312	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	2,296,127		8.00
9.00	Ancillary service charges	6,635,140	2,265,530	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)	8,931,267	2,265,530	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)	8,931,267	2,265,530	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,703,955	2,265,530	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)	1,227,312	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)	1,227,312	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)	1,227,312	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)	1,227,312	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,227,312	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)	1,227,312	0	40.00
41.00	Interim payments	1,227,312	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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/24/2015 9:29 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	9,417,095	0	0	0	1.00
2.00	Temporary investments	25,506,692	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	36,128,735	0	0	0	4.00
5.00	Other receivable	3,487,146	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-19,806,570	0	0	0	6.00
7.00	Inventory	2,298,627	0	0	0	7.00
8.00	Prepaid expenses	222,184	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	57,253,909	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	41,492,166	0	0	0	15.00
16.00	Accumulated depreciation	-28,057,138	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,910,025	0	0	0	19.00
20.00	Accumulated depreciation	-2,823,540	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	17,898,170	0	0	0	23.00
24.00	Accumulated depreciation	-11,934,131	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)	19,485,552	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	140,141	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	140,141	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	76,879,602	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,671,724	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,461,465	0	0	0	38.00
39.00	Payroll taxes payable	590,359	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,372,007	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,095,555	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	24,928,077	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	24,928,077	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	45,023,632	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,855,970				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	31,855,970	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	76,879,602	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/24/2015 9:29 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		25,896,856		25,221		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		30,959,126				2.00
3.00	Total (sum of line 1 and line 2)		56,855,982		25,221		3.00
4.00	GRANT REVENUE	0		0		0	4.00
5.00	CONTRIBUTIONS	0		0		0	5.00
6.00	OTHER ADDITIONS	0		23,727		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00	ROUNDING	2		0		0	9.00
10.00	Total additions (sum of line 4-9)		2		23,727		10.00
11.00	Subtotal (line 3 plus line 10)		56,855,984		48,948		11.00
12.00	TRANSFERS TO AFFILIATES	18,496,287		0		0	12.00
13.00	RELEASED OPERATING	6,480,000		0		0	13.00
14.00	RELEASED CAPITAL	23,727		0		0	14.00
15.00	DISTRIBUTION	0		0		0	15.00
16.00	OTHER DEDUCTION	0		34,590		0	16.00
17.00	OTHER DEDUCTION	0		14,358		0	17.00
18.00	Total deductions (sum of lines 12-17)		25,000,014		48,948		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,855,970		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	GRANT REVENUE		0			4.00
5.00	CONTRIBUTIONS		0			5.00
6.00	OTHER ADDITIONS		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00	ROUNDING		0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFERS TO AFFILIATES		0			12.00
13.00	RELEASED OPERATING		0			13.00
14.00	RELEASED CAPITAL		0			14.00
15.00	DISTRIBUTION		0			15.00
16.00	OTHER DEDUCTION		0			16.00
17.00	OTHER DEDUCTION		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: 150153 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/24/2015 9:29 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	76,597,779		76,597,779	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)	76,597,779		76,597,779	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	76,597,779		76,597,779	17.00
18.00	Ancillary services	250,324,570	96,401,921	346,726,491	18.00
19.00	Outpatient services	2,569,885	8,286,408	10,856,293	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	329,492,234	104,688,329	434,180,563	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		107,433,291		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		107,433,291		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet G-3 Date/Time Prepared: 11/24/2015 9:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	434,180,563	1.00
2.00	Less contractual allowances and discounts on patients' accounts	296,876,198	2.00
3.00	Net patient revenues (line 1 minus line 2)	137,304,365	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	107,433,291	4.00
5.00	Net income from service to patients (line 3 minus line 4)	29,871,074	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	444,680	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	449,043	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	8,092	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS REVENUE	31,647	24.00
24.01	OTHER OPERATING REVENUE	0	24.01
24.02	PURCHASE DISCOUNTS	0	24.02
24.03	NET ASSETS RELEASED FROM RESTRICTION	34,590	24.03
24.04	GAIN/LOSS ON SALE OF ASSETS	120,000	24.04
25.00	Total other income (sum of lines 6-24)	1,088,052	25.00
26.00	Total (line 5 plus line 25)	30,959,126	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	30,959,126	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150153	Period: From 07/01/2014 To 06/30/2015	Worksheet L Parts I-III Date/Time Prepared: 11/24/2015 9:29 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	2,957,949	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	40,762	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)	53.20	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)	1.68	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	3.72	8.00
9.00	Sum of lines 7 and 8	5.40	9.00
10.00	Allowable disproportionate share percentage (see instructions)	1.10	10.00
11.00	Disproportionate share adjustment (see instructions)	32,537	11.00
12.00	Total prospective capital payments (see instructions)	3,031,248	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