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: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet S Parts I-III Date/Time Prepared: 8/31/2016 3:35 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/31/2016 Time: 3:35 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUPONT HOSPITAL (150150) for the cost reporting period beginning 04/01/2015 and ending 03/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

SR VICE PRESIDENT REVENUE MANAGEMENT
Title

08/31/2016
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	-67,725	112,782	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	-67,725	112,782	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2016 2:08 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2520 E. DUPONT ROAD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46825-	County: ALLEN	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	DUPONT HOSPITAL	150150	23060	1	05/24/2001	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2015	03/31/2016	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	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.	649	814	23	75	6,021	343	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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	262,924	97,411	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.03	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

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		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	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: CHS/COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS, INC	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part I Date/Time Prepared: 8/31/2016 2:08 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2016 2:08 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	07/18/2016	Y	07/18/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2016 2:08 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	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.			Y	12/31/2015	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.	BRITTNI		KING		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-2769		BRITTNI_ALLENKING@CHS.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part II Date/Time Prepared: 8/31/2016 2:08 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER - REVENUE MANAGEMENT		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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 8/31/2016 2:08 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	92	33,672	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)		92	33,672	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,660	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	29	10,614	0.00	0	8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		131	47,946	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)		131				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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2016 2:08 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,086	219	12,047			1.00
2.00	HMO and other (see instructions)	1,569	6,655				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)	2,086	219	12,047			7.00
8.00	INTENSIVE CARE UNIT	446	30	1,072			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	473	5,477			8.01
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		205	4,848			13.00
14.00	Total (see instructions)	2,532	927	23,444	0.00	559.64	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	559.64	27.00
28.00	Observation Bed Days		0	1,934			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	343	985			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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2016 2:08 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	744	808	5,200	1.00
2.00	HMO and other (see instructions)			434	0		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
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
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	744	808	5,200	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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 8/31/2016 2:08 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	31,467,102	0	31,467,102	1,164,054.00	27.03	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)		35,566	657,870	693,436	22,217.00	31.21	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		201,351	0	201,351	3,284.75	61.30	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		243,033	0	243,033	2,838.25	85.63	13.00
14.00	Home office salaries & wage-related costs		3,109,397	0	3,109,397	91,205.00	34.09	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)		6,288,252	0	6,288,252			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		135,446	0	135,446			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	112,858	0	112,858	5,459.00	20.67	26.00
27.00	Administrative & General	5.00	5,248,498	-858,985	4,389,513	162,212.75	27.06	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	728,732	0	728,732	37,461.00	19.45	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	316,304	0	316,304	29,584.00	10.69	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,022,242	-677,510	344,732	20,799.26	16.57	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	677,510	677,510	47,182.74	14.36	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,193,142	200,943	1,394,085	34,860.00	39.99	38.00
39.00	Central Services and Supply	14.00	310,789	0	310,789	17,811.00	17.45	39.00
40.00	Pharmacy	15.00	1,210,042	0	1,210,042	26,430.00	45.78	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 8/31/2016 2:08 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	431,364	0	431,364	22,165.00	19.46	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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 8/31/2016 2:08 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		31,467,102	0	31,467,102	1,164,054.00	27.03	1.00
2.00	Excluded area salaries (see instructions)		35,566	657,870	693,436	22,217.00	31.21	2.00
3.00	Subtotal salaries (line 1 minus line 2)		31,431,536	-657,870	30,773,666	1,141,837.00	26.95	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,553,781	0	3,553,781	97,328.00	36.51	4.00
5.00	Subtotal wage-related costs (see inst.)		6,288,252	0	6,288,252	0.00	20.43	5.00
6.00	Total (sum of lines 3 thru 5)		41,273,569	-657,870	40,615,699	1,239,165.00	32.78	6.00
7.00	Total overhead cost (see instructions)		10,573,971	-658,042	9,915,929	403,964.75	24.55	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 8/31/2016 2:08 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	576,775	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)	3,170,363	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	45,073	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	21,016	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	1,764	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	5,476	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	229,270	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	1,789,870	17.00
18.00	Medicare Taxes - Employers Portion Only	418,599	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	82,518	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,340,724	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER BENEFITS, RELOCATION EXPENSES,	82,975	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-3 Part V | Date/Time Prepared: 8/31/2016 2:08 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet S-10 | Date/Time Prepared: 8/31/2016 2:08 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.143602	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,721,845	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	92,046,498	6.00
7.00	Medicaid cost (line 1 times line 6)	13,218,061	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	5,496,216	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)	3,173	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	51,698	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	7,424	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)	4,251	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,500,467	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	88,084	438,422	526,506	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	12,649	62,958	75,607	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)	12,649	62,958	75,607	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)	8,957,431	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	276,286	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	8,681,145	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,246,630	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,322,237	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,822,704	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,489,360	1,489,360	1,443,344	2,932,704	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,702,534	3,702,534	2,648,537	6,351,071	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	112,858	144,513	257,371	4,103,779	4,361,150	4.00
5.01	00570	ADMITTING	0	0	0	2,149,475	2,149,475	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	2,232,684	2,232,684	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	5,248,498	37,313,376	42,561,874	-12,552,304	30,009,570	5.03
7.00	00700	OPERATION OF PLANT	728,732	3,049,542	3,778,274	0	3,778,274	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	408,738	408,738	0	408,738	8.00
9.00	00900	HOUSEKEEPING	316,304	451,106	767,410	0	767,410	9.00
10.00	01000	DIETARY	1,022,242	1,145,754	2,167,996	-1,495,233	672,763	10.00
11.00	01100	CAFETERIA	0	0	0	1,491,291	1,491,291	11.00
13.00	01300	NURSING ADMINISTRATION	1,193,142	265,486	1,458,628	200,571	1,659,199	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	310,789	14,672,575	14,983,364	-13,721,115	1,262,249	14.00
15.00	01500	PHARMACY	1,210,042	4,550,881	5,760,923	-4,541,197	1,219,726	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	431,364	575,284	1,006,648	-6,844	999,804	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,492,793	1,571,552	9,064,345	-3,233,461	5,830,884	30.00
31.00	03100	INTENSIVE CARE UNIT	810,149	216,905	1,027,054	-52	1,027,002	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,252,427	502,552	2,754,979	0	2,754,979	31.01
43.00	04300	NURSERY	-72,659	177,303	104,644	1,133,616	1,238,260	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,822,902	5,446,931	8,269,833	838,035	9,107,868	50.00
51.00	05100	RECOVERY ROOM	1,546,522	382,499	1,929,021	-1,929,021	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-284,696	823,155	538,459	2,090,234	2,628,693	52.00
53.00	05300	ANESTHESIOLOGY	0	1,757,656	1,757,656	-2,169	1,755,487	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,461,634	795,116	2,256,750	-264,670	1,992,080	54.00
54.01	05401	ULTRA SOUND	341,209	29,755	370,964	0	370,964	54.01
56.00	05600	RADIOISOTOPE	62,428	153,458	215,886	0	215,886	56.00
57.00	05700	CT SCAN	278	65,866	66,144	-66,144	0	57.00
58.00	05800	MRI	152,739	28,401	181,140	0	181,140	58.00
60.00	06000	LABORATORY	1,270,040	1,321,809	2,591,849	-129,500	2,462,349	60.00
65.00	06500	RESPIRATORY THERAPY	824,198	521,233	1,345,431	-284,087	1,061,344	65.00
66.00	06600	PHYSICAL THERAPY	146,965	12,372	159,337	142,190	301,527	66.00
67.00	06700	OCCUPATIONAL THERAPY	88,041	6,854	94,895	-94,895	0	67.00
68.00	06800	SPEECH PATHOLOGY	43,597	3,698	47,295	-47,295	0	68.00
69.00	06900	ELECTROCARDIOLOGY	151,796	13,362	165,158	0	165,158	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,006,206	5,006,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,883,591	8,883,591	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,409,323	4,409,323	73.00
74.00	07400	RENAL DIALYSIS	0	84,364	84,364	0	84,364	74.00
76.00	03950	SLEEP LAB	219,571	121,831	341,402	-65,431	275,971	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	298,470	82,938	381,408	0	381,408	90.00
91.00	09100	EMERGENCY	1,229,161	507,955	1,737,116	185	1,737,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	172	13	185	-185	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,431,708	82,396,727	113,828,435	-1,660,542	112,167,893	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,035	35,844	53,879	0	53,879	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,359	74,127	91,486	3,862	95,348	192.00
194.00	07950	MARKETING	0	0	0	1,077,588	1,077,588	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	1,576	1,576	0	1,576	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	0	579,092	579,092	194.03
200.00		TOTAL (SUM OF LINES 118-199)	31,467,102	82,508,274	113,975,376	0	113,975,376	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	989,173	3,921,877		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	45,200	6,396,271		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,515	4,359,635		4.00
5.01	00570	ADMITTING	0	2,149,475		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	172,279	2,404,963		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-17,562,536	12,447,034		5.03
7.00	00700	OPERATION OF PLANT	-24,526	3,753,748		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-31,146	377,592		8.00
9.00	00900	HOUSEKEEPING	0	767,410		9.00
10.00	01000	DIETARY	0	672,763		10.00
11.00	01100	CAFETERIA	-377,479	1,113,812		11.00
13.00	01300	NURSING ADMINISTRATION	-6,728	1,652,471		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,262,249		14.00
15.00	01500	PHARMACY	0	1,219,726		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-815	998,989		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-507,827	5,323,057		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,027,002		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-77,080	2,677,899		31.01
43.00	04300	NURSERY	0	1,238,260		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	9,107,868		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-403,450	2,225,243		52.00
53.00	05300	ANESTHESIOLOGY	-1,755,487	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,949	1,985,131		54.00
54.01	05401	ULTRA SOUND	0	370,964		54.01
56.00	05600	RADIOISOTOPE	0	215,886		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	181,140		58.00
60.00	06000	LABORATORY	-38,072	2,424,277		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,061,344		65.00
66.00	06600	PHYSICAL THERAPY	0	301,527		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	165,158		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,006,206		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,883,591		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,409,323		73.00
74.00	07400	RENAL DIALYSIS	0	84,364		74.00
76.00	03950	SLEEP LAB	0	275,971		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	381,408		90.00
91.00	09100	EMERGENCY	-105,090	1,632,211		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-19,692,048	92,475,845		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	53,879		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	95,348		192.00
194.00	07950	MARKETING	0	1,077,588		194.00
194.01	07951	PHYSICIAN RELATIONS	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	1,576		194.02
194.03	07953	WOMENS RESOURCE CENTER	0	579,092		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-19,692,048	94,283,328		200.00

RECLASSIFICATIONS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-6 | Date/Time Prepared: 8/31/2016 2:08 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,104,006	1.00
	TOTALS		0	4,104,006	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	313,464	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	313,464	
	C - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	118,965	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,644,722	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,862	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	2,767,549	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	100,418	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,223,961	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,815	3.00
	TOTALS		0	1,328,194	
	E - MARKETING				
1.00	MARKETING	194.00	141,188	936,400	1.00
	TOTALS		141,188	936,400	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,692,742	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,883,591	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	13,576,333	
	H - DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,409,323	1.00
	TOTALS		0	4,409,323	
	I - MISCELLANEOUS				
1.00	ADMITTING	5.01	1,852,079	297,396	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.02	0	2,232,684	2.00
	TOTALS		1,852,079	2,530,080	
	J - RADIOLOGY COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	278	65,866	1.00
	TOTALS		278	65,866	
	K - DIETARY				
1.00	CAFETERIA	11.00	677,510	813,781	1.00
	TOTALS		677,510	813,781	
	L - MISC DEPT RECLASS				
1.00	OPERATING ROOM	50.00	1,546,522	384,668	1.00
2.00	PHYSICAL THERAPY	66.00	131,638	10,552	2.00
3.00	EMERGENCY	91.00	172	13	3.00
4.00	WOMENS RESOURCE CENTER	194.03	516,854	62,238	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		2,195,186	457,471	
	M - LABOR & DELIVERY COSTS				
1.00	NURSERY	43.00	1,083,872	49,744	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,072,920	17,314	2.00
	TOTALS		3,156,792	67,058	
	N - CNO COSTS				
1.00	NURSING ADMINISTRATION	13.00	200,943	0	1.00
	TOTALS		200,943	0	
500.00	Grand Total: Increases		8,223,976	31,369,525	500.00

RECLASSIFICATIONS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-6 | Date/Time Prepared: 8/31/2016 2:08 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFIT RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	4,104,006	0		1.00
	TOTALS		0	4,104,006			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	29,377	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	284,087	0		2.00
	TOTALS		0	313,464			
	C - RENTAL AND LEASE EXPENSES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	227	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	880,322	10		2.00
3.00		0.00	0	0	0		3.00
4.00	DIETARY	10.00	0	3,942	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	372	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	256,797	0		6.00
7.00	PHARMACY	15.00	0	131,874	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,844	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	9,611	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	52	0		10.00
11.00	OPERATING ROOM	50.00	0	953,190	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	329,387	0		12.00
13.00	LABORATORY	60.00	0	129,500	0		13.00
14.00	SLEEP LAB	76.00	0	65,431	0		14.00
	TOTALS		0	2,767,549			
	D - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	1,328,194	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	1,328,194			
	E - MARKETING						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	141,188	936,400	0		1.00
	TOTALS		141,188	936,400			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,434,941	0		1.00
2.00	OPERATING ROOM	50.00	0	139,965	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,427	0		3.00
	TOTALS		0	13,576,333			
	H - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	4,409,323	0		1.00
	TOTALS		0	4,409,323			
	I - MISCELLANEOUS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	1,852,079	2,530,080	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,852,079	2,530,080			
	J - RADIOLOGY COSTS						
1.00	CT SCAN	57.00	278	65,866	0		1.00
	TOTALS		278	65,866			
	K - DIETARY						
1.00	DIETARY	10.00	677,510	813,781	0		1.00
	TOTALS		677,510	813,781			
	L - MISC DEPT RECLASS						
1.00	RECOVERY ROOM	51.00	1,546,522	382,499	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	2,169	0		2.00
3.00	OCCUPATIONAL THERAPY	67.00	88,041	6,854	0		3.00
4.00	SPEECH PATHOLOGY	68.00	43,597	3,698	0		4.00
5.00	AMBULANCE SERVICES	95.00	172	13	0		5.00
6.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	516,854	62,238	0		6.00
	TOTALS		2,195,186	457,471			
	M - LABOR & DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	3,156,792	67,058	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		3,156,792	67,058			
	N - CNO COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	200,943	0	0		1.00
	TOTALS		200,943	0			
500.00	Grand Total: Decreases		8,223,976	31,369,525			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-7 Part I Date/Time Prepared: 8/31/2016 2:08 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,732,541	0	0	0	0	1.00
2.00	Land Improvements	445,674	0	0	0	0	2.00
3.00	Buildings and Fixtures	55,661,764	0	0	0	0	3.00
4.00	Building Improvements	3,989,303	0	0	0	0	4.00
5.00	Fixed Equipment	3,954,346	0	0	0	0	5.00
6.00	Movable Equipment	54,483,954	0	0	0	415,620	6.00
7.00	HIT designated Assets	377,129	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	120,644,711	0	0	0	415,620	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	120,644,711	0	0	0	415,620	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,732,541	0	1.00
2.00	Land Improvements	445,674	0	2.00
3.00	Buildings and Fixtures	55,661,764	0	3.00
4.00	Building Improvements	3,989,303	0	4.00
5.00	Fixed Equipment	3,954,346	0	5.00
6.00	Movable Equipment	54,068,334	0	6.00
7.00	HIT designated Assets	377,129	0	7.00
8.00	Subtotal (sum of lines 1-7)	120,229,091	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	120,229,091	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 8/31/2016 2:08 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,489,360	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,702,534	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,191,894	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,489,360		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,702,534		2.00
3.00	Total (sum of lines 1-2)	0	5,191,894		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 8/31/2016 2:08 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	61,829,281	0	61,829,281	0.514262	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	58,399,809	0	58,399,809	0.485738	0	2.00
3.00	Total (sum of lines 1-2)	120,229,090	0	120,229,090	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	1,857,651	118,965	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,998,162	2,315,026	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,855,813	2,433,991	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	620,882	100,418	1,223,961	0	3,921,877	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	79,268	3,815	0	0	6,396,271	2.00
3.00	Total (sum of lines 1-2)	700,150	104,233	1,223,961	0	10,318,148	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-8 | Date/Time Prepared: 8/31/2016 2:08 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	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	-2,891,728			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	-255,307			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-377,479	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	-815	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	-2,006	NURSING ADMINISTRATION	13.00	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	A	368,291	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	295,628	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SILVER RECOVERY	B	-6,949	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00
35.00	RENTAL INCOME	B	-53,096	CAP REL COSTS-MVBLE EQUIP	2.00	10	35.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-8 | Date/Time Prepared: 8/31/2016 2:08 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
36.00	MISC INCOME	B	-513,865	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	36.00
37.00			0		0.00	0	37.00
38.00	PATIENT PHONE WAGE COST	A	-7,423	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	38.00
39.00	PATIENT PHONE BENEFITS COST	A	-1,515	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	PATIENT PHONE EXPENSE	A	-5,057	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	40.00
41.00	PATIENT TV EXPENSE	A	-24,526	OPERATION OF PLANT	7.00	0	41.00
42.00	MARKETING	A	-22,553	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	42.00
43.00	MINORITY INTEREST	A	-15,164,932	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	43.00
44.00	PHYSICIAN RECRUITING	A	-607,800	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	44.00
45.00	LOBBYING EXPENSE	A	-10,043	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.00
45.01	CHARITABLE CONTRIBUTIONS	A	-85,148	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.01
45.03	MOB SUPPORT COSTS	A	-276,600	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.03
45.04	LEGAL FEES	A	-49,125	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.04
45.06			0		0.00	0	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-19,692,048				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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 8/31/2016 2:08 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION INTEREST	515,275	0	1.00
2.00	5.02	CASHIERING/ACCOUNTS RECEIVAB	PASI OPERATING COSTS	371,080	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	23,710	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	3,463	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	POOLED CAPITAL - BLDGS	18,456	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	POOLED CAPITAL - FIXTURES	122,529	0	4.02
4.03	5.03	OTHER ADMINISTRATIVE AND GEN	POOLED ADMIN COSTS	1,767,726	0	4.03
4.04	5.03	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	1,455,526	4.04
4.05	5.03	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	5,654	4.05
4.06	5.03	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	218,940	4.06
4.07	5.03	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	1,452,556	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	5.02	CASHIERING/ACCOUNTS RECEIVAB	PPSI FEES	0	14,760	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	5.02	CASHIERING/ACCOUNTS RECEIVAB	PASI COLLECTION FEES	0	115,730	4.15
4.16	5.02	CASHIERING/ACCOUNTS RECEIVAB	PASI LIEN UNIT	0	60,310	4.16
4.17	5.03	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE	360,335	379,903	4.17
4.18	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY - OPERATING	377,592	408,738	4.18
4.19	1.00	CAP REL COSTS-BLDG & FIXT	LAUNDRY - CAPITAL	44,867	0	4.19
4.20	1.00	CAP REL COSTS-BLDG & FIXT	DSC BLDG LEASE SJH	627,201	613,320	4.20
4.22	1.00	CAP REL COSTS-BLDG & FIXT	PRE-ACQUISITION LEGACY CAPIT	4,693	0	4.22
4.23	2.00	CAP REL COSTS-MVBLE EQUIP	PRE-ACQUISITION LEGACY CAPIT	27,712	0	4.23
4.24	5.03	OTHER ADMINISTRATIVE AND GEN	PRE-ACQUISITION PERIOD NON-C	287,928	0	4.24
4.25	5.02	CASHIERING/ACCOUNTS RECEIVAB	EBOS FEES	0	8,001	4.25
4.26	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	261,926	336,362	4.26
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,814,493	5,069,800	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	CHS, INC.	72.03	CHS, INC.	72.03	6.00
7.00	B	HOSPITAL LAUNDR	100.00	HOSPITAL LAUNDR	100.00	7.00
8.00	B	LUTHERAN HEALTH	100.00	LUTHERAN HEALTH	100.00	8.00
9.00	B	PASI	100.00	PASI	100.00	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: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet A-8-1 Date/Time Prepared: 8/31/2016 2:08 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	515,275	11		1.00
2.00	371,080	0		2.00
3.00	23,710	11		3.00
4.00	3,463	11		4.00
4.01	18,456	11		4.01
4.02	122,529	11		4.02
4.03	1,767,726	0		4.03
4.04	-1,455,526	0		4.04
4.05	-5,654	0		4.05
4.06	-218,940	0		4.06
4.07	-1,452,556	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	-14,760	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	-115,730	0		4.15
4.16	-60,310	0		4.16
4.17	-19,568	0		4.17
4.18	-31,146	0		4.18
4.19	44,867	11		4.19
4.20	13,881	11		4.20
4.22	4,693	11		4.22
4.23	27,712	11		4.23
4.24	287,928	0		4.24
4.25	-8,001	0		4.25
4.26	-74,436	11		4.26
5.00	-255,307			5.00

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

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

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

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

6.00	HOSPITAL MANAGEMENT		6.00
7.00	LAUNDRY		7.00
8.00	HOSPITAL NETWOR		8.00
9.00	DEBT COLLECTION		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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 8/31/2016 2:08 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	69,123	0	69,123	171,400	966	1.00
2.00	13.00	NURSING ADMINISTRATION	8,760	0	8,760	171,400	49	2.00
3.00	30.00	ADULTS & PEDIATRICS	507,827	507,827	0	0	0	3.00
4.00	31.01	NEONATAL INTENSIVE CARE UNIT	77,080	77,080	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	403,450	403,450	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	1,755,487	1,755,487	0	0	0	6.00
7.00	60.00	LABORATORY	38,072	38,072	0	0	0	7.00
8.00	91.00	EMERGENCY	105,090	105,090	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			2,964,889	2,887,006	77,883		1,015	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	79,602	3,980	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	4,038	202	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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			83,640	4,182	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	0	79,602	0	0		1.00
2.00	13.00	NURSING ADMINISTRATION	0	4,038	4,722	4,722		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	507,827		3.00
4.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	77,080		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	403,450		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	1,755,487		6.00
7.00	60.00	LABORATORY	0	0	0	38,072		7.00
8.00	91.00	EMERGENCY	0	0	0	105,090		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	83,640	4,722	2,891,728		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part I | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,921,877	3,921,877				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,396,271		6,396,271			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,359,635	10,041	16,376	4,386,052		4.00
5.01	00570	ADMITTING	2,149,475	0	0	259,082	2,408,557	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,404,963	0	0	0	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	12,447,034	131,808	214,969	354,954	0	5.03
7.00	00700	OPERATION OF PLANT	3,753,748	1,085,759	1,770,784	101,940	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	377,592	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	767,410	12,168	19,845	44,247	0	9.00
10.00	01000	DIETARY	672,763	99,523	162,314	48,224	0	10.00
11.00	01100	CAFETERIA	1,113,812	0	0	94,775	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,652,471	0	0	195,014	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,262,249	36,888	60,161	43,475	0	14.00
15.00	01500	PHARMACY	1,219,726	20,727	33,805	169,269	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	998,989	13,005	21,210	60,342	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,323,057	803,733	1,310,824	606,550	131,282	30.00
31.00	03100	INTENSIVE CARE UNIT	1,027,002	117,531	191,684	113,329	16,986	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,677,899	169,567	276,551	315,085	101,212	31.01
43.00	04300	NURSERY	1,238,260	53,309	86,943	141,456	28,473	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,107,868	786,945	1,283,445	611,228	725,670	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,225,243	0	0	250,149	50,352	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,985,131	162,455	264,951	204,502	174,528	54.00
54.01	05401	ULTRA SOUND	370,964	0	0	47,731	55,058	54.01
56.00	05600	RADIOISOTOPE	215,886	0	0	8,733	13,027	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	181,140	30,054	49,016	21,366	44,278	58.00
60.00	06000	LABORATORY	2,424,277	34,342	56,010	177,662	189,842	60.00
65.00	06500	RESPIRATORY THERAPY	1,061,344	0	0	115,295	34,612	65.00
66.00	06600	PHYSICAL THERAPY	301,527	10,425	17,002	38,973	8,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	165,158	0	0	21,234	10,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,006,206	0	0	0	154,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,883,591	0	0	0	255,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,409,323	0	0	0	254,473	73.00
74.00	07400	RENAL DIALYSIS	84,364	0	0	0	1,607	74.00
76.00	03950	SLEEP LAB	275,971	38,979	63,572	30,715	13,059	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	381,408	0	0	41,752	9,453	90.00
91.00	09100	EMERGENCY	1,632,211	138,991	226,683	171,968	134,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,475,845	3,756,250	6,126,145	4,289,050	2,408,557	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	53,879	9,849	16,064	2,523	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	95,348	0	0	2,428	0	192.00
194.00	07950	MARKETING	1,077,588	0	0	19,750	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	1,576	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	579,092	155,778	254,062	72,301	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	94,283,328	3,921,877	6,396,271	4,386,052	2,408,557	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part I | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,404,963					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	13,148,765	13,148,765			5.03
7.00	00700	OPERATION OF PLANT	0	6,712,231	1,087,791	7,800,022		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	377,592	61,193	0	438,785	8.00
9.00	00900	HOUSEKEEPING	0	843,670	136,726	35,227	0	9.00
10.00	01000	DIETARY	0	982,824	159,277	288,123	0	10.00
11.00	01100	CAFETERIA	0	1,208,587	195,865	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,847,485	299,405	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,402,773	227,335	106,791	862	14.00
15.00	01500	PHARMACY	0	1,443,527	233,939	60,007	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,093,546	177,221	37,649	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	131,075	8,306,521	1,346,163	2,326,840	78,352	30.00
31.00	03100	INTENSIVE CARE UNIT	16,959	1,483,491	240,416	340,257	16,917	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	101,053	3,641,367	590,124	490,905	11,418	31.01
43.00	04300	NURSERY	28,428	1,576,869	255,549	154,332	9,231	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	724,733	13,239,889	2,145,686	2,278,239	105,036	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,273	2,576,017	417,472	0	122,722	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	174,252	2,965,819	480,644	470,314	34,670	54.00
54.01	05401	ULTRA SOUND	54,971	528,724	85,686	0	0	54.01
56.00	05600	RADIOISOTOPE	13,007	250,653	40,621	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	44,208	370,062	59,973	87,007	0	58.00
60.00	06000	LABORATORY	189,542	3,071,675	497,799	99,422	16	60.00
65.00	06500	RESPIRATORY THERAPY	34,557	1,245,808	201,897	0	0	65.00
66.00	06600	PHYSICAL THERAPY	8,875	385,691	62,505	30,180	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,494	207,397	33,611	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	154,068	5,314,586	861,287	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	255,560	9,395,115	1,522,582	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	254,071	4,917,867	796,994	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,605	87,576	14,193	0	0	74.00
76.00	03950	SLEEP LAB	13,038	435,334	70,551	112,847	8,167	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,438	442,051	71,639	0	0	90.00
91.00	09100	EMERGENCY	134,756	2,439,578	395,360	402,383	51,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,404,963	91,943,090	12,769,504	7,320,523	438,785	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	82,315	13,340	28,515	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	97,776	15,846	0	0	192.00
194.00	07950	MARKETING	0	1,097,338	177,836	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	1,576	255	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	1,061,233	171,984	450,984	0	194.03
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)	2,404,963	94,283,328	13,148,765	7,800,022	438,785	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part I | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,015,623					9.00
10.00	01000	DIETARY	37,686	1,467,910				10.00
11.00	01100	CAFETERIA	0	316,494	1,720,946			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	69,652	2,216,542		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,968	0	35,574	0	1,787,303	14.00
15.00	01500	PHARMACY	7,849	0	52,821	91,510	5,523	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,924	0	44,302	0	597	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	304,349	1,119,675	301,010	521,484	27,273	30.00
31.00	03100	INTENSIVE CARE UNIT	44,505	31,741	48,582	84,166	8,438	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	64,210	0	149,778	259,482	21,725	31.01
43.00	04300	NURSERY	20,186	0	65,746	113,901	17,143	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	297,990	0	326,153	565,046	300,604	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	116,240	201,379	38,086	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,516	0	104,146	0	27,979	54.00
54.01	05401	ULTRA SOUND	0	0	20,904	0	331	54.01
56.00	05600	RADIOISOTOPE	0	0	4,364	0	31	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	11,380	0	9,600	0	1,547	58.00
60.00	06000	LABORATORY	13,004	0	108,634	0	39,210	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	60,260	104,398	11,804	65.00
66.00	06600	PHYSICAL THERAPY	3,947	0	14,130	24,479	172	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	17,953	31,103	30	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	432,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	819,506	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	14,760	0	20,322	35,207	1,933	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	15,626	27,071	5,135	90.00
91.00	09100	EMERGENCY	52,631	0	90,806	157,316	22,268	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	952,905	1,467,910	1,676,603	2,216,542	1,782,236	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,730	0	1,995	0	2,405	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,288	0	212	192.00
194.00	07950	MARKETING	0	0	8,894	0	225	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	58,988	0	32,166	0	2,225	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,015,623	1,467,910	1,720,946	2,216,542	1,787,303	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part I | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,895,176					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,358,239				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	74,032	14,405,699	0	14,405,699	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,578	2,308,091	0	2,308,091	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	57,075	5,286,084	0	5,286,084	31.01
43.00	04300	NURSERY	0	16,057	2,229,014	0	2,229,014	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	409,237	19,667,880	0	19,667,880	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,394	3,500,310	0	3,500,310	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,419	4,243,507	0	4,243,507	54.00
54.01	05401	ULTRA SOUND	0	31,048	666,693	0	666,693	54.01
56.00	05600	RADIOISOTOPE	0	7,346	303,015	0	303,015	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	24,969	564,538	0	564,538	58.00
60.00	06000	LABORATORY	0	107,054	3,936,814	0	3,936,814	60.00
65.00	06500	RESPIRATORY THERAPY	0	19,518	1,643,685	0	1,643,685	65.00
66.00	06600	PHYSICAL THERAPY	0	5,013	526,117	0	526,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,927	296,021	0	296,021	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	87,018	6,695,792	0	6,695,792	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	144,341	11,881,544	0	11,881,544	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,895,176	143,501	7,753,538	0	7,753,538	73.00
74.00	07400	RENAL DIALYSIS	0	906	102,675	0	102,675	74.00
76.00	03950	SLEEP LAB	0	7,364	706,485	0	706,485	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,331	566,853	0	566,853	90.00
91.00	09100	EMERGENCY	0	76,111	3,687,847	0	3,687,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,895,176	1,358,239	90,972,202	0	90,972,202	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	132,300	0	132,300	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	115,122	0	115,122	192.00
194.00	07950	MARKETING	0	0	1,284,293	0	1,284,293	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	1,831	0	1,831	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	1,777,580	0	1,777,580	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,895,176	1,358,239	94,283,328	0	94,283,328	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part II | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,041	16,376	26,417	26,417	4.00
5.01	00570	ADMITTING	0	0	0	0	1,561	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	131,808	214,969	346,777	2,139	5.03
7.00	00700	OPERATION OF PLANT	0	1,085,759	1,770,784	2,856,543	614	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	12,168	19,845	32,013	267	9.00
10.00	01000	DIETARY	0	99,523	162,314	261,837	291	10.00
11.00	01100	CAFETERIA	0	0	0	0	571	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	1,175	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,888	60,161	97,049	262	14.00
15.00	01500	PHARMACY	0	20,727	33,805	54,532	1,020	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,005	21,210	34,215	364	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	803,733	1,310,824	2,114,557	3,655	30.00
31.00	03100	INTENSIVE CARE UNIT	0	117,531	191,684	309,215	683	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	169,567	276,551	446,118	1,899	31.01
43.00	04300	NURSERY	0	53,309	86,943	140,252	852	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	786,945	1,283,445	2,070,390	3,668	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	1,507	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	162,455	264,951	427,406	1,232	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	288	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	53	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	30,054	49,016	79,070	129	58.00
60.00	06000	LABORATORY	0	34,342	56,010	90,352	1,071	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	695	65.00
66.00	06600	PHYSICAL THERAPY	0	10,425	17,002	27,427	235	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	128	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	38,979	63,572	102,551	185	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	252	90.00
91.00	09100	EMERGENCY	0	138,991	226,683	365,674	1,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,756,250	6,126,145	9,882,395	25,832	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,849	16,064	25,913	15	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	15	192.00
194.00	07950	MARKETING	0	0	0	0	119	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	155,778	254,062	409,840	436	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,921,877	6,396,271	10,318,148	26,417	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part II | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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
5.01	00570	ADMITTING	1,561					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	348,916			5.03
7.00	00700	OPERATION OF PLANT	0	0	28,863	2,886,020		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,624	0	1,624	8.00
9.00	00900	HOUSEKEEPING	0	0	3,628	13,034	0	9.00
10.00	01000	DIETARY	0	0	4,226	106,606	0	10.00
11.00	01100	CAFETERIA	0	0	5,197	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,944	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	6,032	39,513	3	14.00
15.00	01500	PHARMACY	0	0	6,207	22,203	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	4,702	13,930	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69	0	35,718	860,933	290	30.00
31.00	03100	INTENSIVE CARE UNIT	9	0	6,379	125,896	63	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	53	0	15,658	181,636	42	31.01
43.00	04300	NURSERY	15	0	6,781	57,103	34	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	675	0	56,967	842,952	389	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26	0	11,077	0	455	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92	0	12,753	174,017	128	54.00
54.01	05401	ULTRA SOUND	29	0	2,274	0	0	54.01
56.00	05600	RADIOISOTOPE	7	0	1,078	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	23	0	1,591	32,193	0	58.00
60.00	06000	LABORATORY	100	0	13,208	36,786	0	60.00
65.00	06500	RESPIRATORY THERAPY	18	0	5,357	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5	0	1,658	11,167	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6	0	892	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81	0	22,853	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135	0	40,399	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134	0	21,147	0	0	73.00
74.00	07400	RENAL DIALYSIS	1	0	377	0	0	74.00
76.00	03950	SLEEP LAB	7	0	1,872	41,754	30	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5	0	1,901	0	0	90.00
91.00	09100	EMERGENCY	71	0	10,490	148,882	190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,561	0	338,853	2,708,605	1,624	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	354	10,550	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	420	0	0	192.00
194.00	07950	MARKETING	0	0	4,719	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	7	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	4,563	166,865	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,561	0	348,916	2,886,020	1,624	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part II | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	48,942					9.00
10.00	01000	DIETARY	1,816	374,776				10.00
11.00	01100	CAFETERIA	0	80,805	86,573			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	3,504	12,623		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	673	0	1,790	0	145,322	14.00
15.00	01500	PHARMACY	378	0	2,657	521	449	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	237	0	2,229	0	49	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,667	285,867	15,142	2,970	2,218	30.00
31.00	03100	INTENSIVE CARE UNIT	2,145	8,104	2,444	479	686	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	3,094	0	7,535	1,478	1,766	31.01
43.00	04300	NURSERY	973	0	3,307	649	1,394	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,360	0	16,408	3,217	24,443	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	5,847	1,147	3,097	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,964	0	5,239	0	2,275	54.00
54.01	05401	ULTRA SOUND	0	0	1,052	0	27	54.01
56.00	05600	RADIOISOTOPE	0	0	220	0	3	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	548	0	483	0	126	58.00
60.00	06000	LABORATORY	627	0	5,465	0	3,188	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,031	595	960	65.00
66.00	06600	PHYSICAL THERAPY	190	0	711	139	14	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	903	177	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	35,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	66,627	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	711	0	1,022	201	157	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	786	154	418	90.00
91.00	09100	EMERGENCY	2,536	0	4,568	896	1,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,919	374,776	84,343	12,623	144,910	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	180	0	100	0	196	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	65	0	17	192.00
194.00	07950	MARKETING	0	0	447	0	18	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	2,843	0	1,618	0	181	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	48,942	374,776	86,573	12,623	145,322	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B Part II Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	87,967					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,726				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,039	3,339,125	0	3,339,125	30.00
31.00	03100	INTENSIVE CARE UNIT	0	393	456,496	0	456,496	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	2,343	661,622	0	661,622	31.01
43.00	04300	NURSERY	0	659	212,019	0	212,019	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,774	3,050,243	0	3,050,243	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,165	24,321	0	24,321	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,040	630,146	0	630,146	54.00
54.01	05401	ULTRA SOUND	0	1,274	4,944	0	4,944	54.01
56.00	05600	RADIOISOTOPE	0	302	1,663	0	1,663	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	1,025	115,188	0	115,188	58.00
60.00	06000	LABORATORY	0	4,394	155,191	0	155,191	60.00
65.00	06500	RESPIRATORY THERAPY	0	801	11,457	0	11,457	65.00
66.00	06600	PHYSICAL THERAPY	0	206	41,752	0	41,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	243	2,351	0	2,351	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,572	61,706	0	61,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,924	113,085	0	113,085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,967	5,890	115,138	0	115,138	73.00
74.00	07400	RENAL DIALYSIS	0	37	415	0	415	74.00
76.00	03950	SLEEP LAB	0	302	148,792	0	148,792	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	219	3,735	0	3,735	90.00
91.00	09100	EMERGENCY	0	3,124	539,278	0	539,278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,967	55,726	9,688,667	0	9,688,667	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	37,308	0	37,308	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	517	0	517	192.00
194.00	07950	MARKETING	0	0	5,303	0	5,303	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	7	0	7	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	0	586,346	0	586,346	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	87,967	55,726	10,318,148	0	10,318,148	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B-1 | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	224,973					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		224,973				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	576	576	31,354,244			4.00
5.01	00570	ADMITTING	0	0	1,852,079	633,504,190		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	633,504,190	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	7,561	7,561	2,537,434	0	0	5.03
7.00	00700	OPERATION OF PLANT	62,283	62,283	728,732	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	698	698	316,304	0	0	9.00
10.00	01000	DIETARY	5,709	5,709	344,732	0	0	10.00
11.00	01100	CAFETERIA	0	0	677,510	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,394,085	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,116	2,116	310,789	0	0	14.00
15.00	01500	PHARMACY	1,189	1,189	1,210,042	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	746	746	431,364	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,105	46,105	4,336,001	34,529,726	34,529,726	30.00
31.00	03100	INTENSIVE CARE UNIT	6,742	6,742	810,149	4,467,572	4,467,572	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	9,727	9,727	2,252,427	26,620,810	26,620,810	31.01
43.00	04300	NURSERY	3,058	3,058	1,011,213	7,489,065	7,489,065	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,142	45,142	4,369,424	190,872,233	190,872,233	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,788,224	13,243,630	13,243,630	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,319	9,319	1,461,912	45,904,221	45,904,221	54.00
54.01	05401	ULTRA SOUND	0	0	341,209	14,481,417	14,481,417	54.01
56.00	05600	RADIOISOTOPE	0	0	62,428	3,426,429	3,426,429	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	1,724	1,724	152,739	11,645,910	11,645,910	58.00
60.00	06000	LABORATORY	1,970	1,970	1,270,040	49,932,118	49,932,118	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	824,198	9,103,534	9,103,534	65.00
66.00	06600	PHYSICAL THERAPY	598	598	278,603	2,338,078	2,338,078	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	151,796	2,764,549	2,764,549	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	40,586,974	40,586,974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	67,323,398	67,323,398	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	66,931,328	66,931,328	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	422,695	422,695	74.00
76.00	03950	SLEEP LAB	2,236	2,236	219,571	3,434,754	3,434,754	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	298,470	2,486,333	2,486,333	90.00
91.00	09100	EMERGENCY	7,973	7,973	1,229,333	35,499,416	35,499,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	215,472	215,472	30,660,808	633,504,190	633,504,190	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	565	565	18,035	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	17,359	0	0	192.00
194.00	07950	MARKETING	0	0	141,188	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	8,936	8,936	516,854	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,921,877	6,396,271	4,386,052	2,408,557	2,404,963	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.432656	28.431283	0.139887	0.003802	0.003796	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			26,417	1,561	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000843	0.000002	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B-1 | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-13,148,765	81,134,563				5.03
7.00	00700	OPERATION OF PLANT	0	6,712,231	154,553			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	377,592	0	610,541		8.00
9.00	00900	HOUSEKEEPING	0	843,670	698	0	153,855	9.00
10.00	01000	DIETARY	0	982,824	5,709	0	5,709	10.00
11.00	01100	CAFETERIA	0	1,208,587	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,847,485	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,402,773	2,116	1,200	2,116	14.00
15.00	01500	PHARMACY	0	1,443,527	1,189	0	1,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,093,546	746	0	746	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,306,521	46,105	109,022	46,105	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,483,491	6,742	23,539	6,742	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	3,641,367	9,727	15,887	9,727	31.01
43.00	04300	NURSERY	0	1,576,869	3,058	12,844	3,058	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,239,889	45,142	146,151	45,142	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,576,017	0	170,760	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,965,819	9,319	48,241	9,319	54.00
54.01	05401	ULTRA SOUND	0	528,724	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	250,653	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	370,062	1,724	0	1,724	58.00
60.00	06000	LABORATORY	0	3,071,675	1,970	22	1,970	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,245,808	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	385,691	598	0	598	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	207,397	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,314,586	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,395,115	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,917,867	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	87,576	0	0	0	74.00
76.00	03950	SLEEP LAB	0	435,334	2,236	11,364	2,236	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	442,051	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,439,578	7,973	71,511	7,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-13,148,765	78,794,325	145,052	610,541	144,354	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	82,315	565	0	565	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	97,776	0	0	0	192.00
194.00	07950	MARKETING	0	1,097,338	0	0	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	1,576	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	1,061,233	8,936	0	8,936	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		13,148,765	7,800,022	438,785	1,015,623	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.162061	50.468267	0.718682	6.601170	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		348,916	2,886,020	1,624	48,942	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004300	18.673335	0.002660	0.318105	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B-1 | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	74,088					10.00
11.00	01100	CAFETERIA	15,974	41,410				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,676	30,786			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	856	0	19,374,717		14.00
15.00	01500	PHARMACY	0	1,271	1,271	59,866	4,409,323	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,066	0	6,477	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,512	7,243	7,243	295,644	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,602	1,169	1,169	91,468	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	3,604	3,604	235,499	0	31.01
43.00	04300	NURSERY	0	1,582	1,582	185,837	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,848	7,848	3,258,614	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,797	2,797	412,866	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,506	0	303,296	0	54.00
54.01	05401	ULTRA SOUND	0	503	0	3,587	0	54.01
56.00	05600	RADIOISOTOPE	0	105	0	339	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	231	0	16,766	0	58.00
60.00	06000	LABORATORY	0	2,614	0	425,047	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,450	1,450	127,961	0	65.00
66.00	06600	PHYSICAL THERAPY	0	340	340	1,865	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	432	432	324	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,692,742	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,883,591	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,409,323	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	489	489	20,958	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	376	376	55,665	0	90.00
91.00	09100	EMERGENCY	0	2,185	2,185	241,391	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,088	40,343	30,786	19,319,803	4,409,323	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	48	0	26,066	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31	0	2,297	0	192.00
194.00	07950	MARKETING	0	214	0	2,434	0	194.00
194.01	07951	PHYSICIAN RELATIONS	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	WOMENS RESOURCE CENTER	0	774	0	24,117	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,467,910	1,720,946	2,216,542	1,787,303	1,895,176	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.813060	41.558706	71.998376	0.092249	0.429811	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	374,776	86,573	12,623	145,322	87,967	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.058525	2.090630	0.410024	0.007501	0.019950	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet B-1 | Date/Time Prepared: 8/31/2016 2:08 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			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
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	633,504,190		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	34,529,726		30.00
31.00	03100	INTENSIVE CARE UNIT	4,467,572		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	26,620,810		31.01
43.00	04300	NURSERY	7,489,065		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	190,872,233		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,243,630		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,904,221		54.00
54.01	05401	ULTRA SOUND	14,481,417		54.01
56.00	05600	RADIOISOTOPE	3,426,429		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	11,645,910		58.00
60.00	06000	LABORATORY	49,932,118		60.00
65.00	06500	RESPIRATORY THERAPY	9,103,534		65.00
66.00	06600	PHYSICAL THERAPY	2,338,078		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,764,549		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,586,974		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,323,398		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,931,328		73.00
74.00	07400	RENAL DIALYSIS	422,695		74.00
76.00	03950	SLEEP LAB	3,434,754		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2,486,333		90.00
91.00	09100	EMERGENCY	35,499,416		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	633,504,190		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	PHYSICIAN RELATIONS	0		194.01
194.02	07952	SENIOR CIRCLE	0		194.02
194.03	07953	WOMENS RESOURCE CENTER	0		194.03
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,358,239		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002144		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,726		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000088		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part I Date/Time Prepared: 8/31/2016 2:08 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,405,699		14,405,699	0	14,405,699	30.00
31.00	03100	INTENSIVE CARE UNIT	2,308,091		2,308,091	0	2,308,091	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	5,286,084		5,286,084	0	5,286,084	31.01
43.00	04300	NURSERY	2,229,014		2,229,014	0	2,229,014	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,667,880		19,667,880	0	19,667,880	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,500,310		3,500,310	0	3,500,310	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,243,507		4,243,507	0	4,243,507	54.00
54.01	05401	ULTRA SOUND	666,693		666,693	0	666,693	54.01
56.00	05600	RADIOISOTOPE	303,015		303,015	0	303,015	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	564,538		564,538	0	564,538	58.00
60.00	06000	LABORATORY	3,936,814		3,936,814	0	3,936,814	60.00
65.00	06500	RESPIRATORY THERAPY	1,643,685	0	1,643,685	0	1,643,685	65.00
66.00	06600	PHYSICAL THERAPY	526,117	0	526,117	0	526,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	296,021		296,021	0	296,021	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,695,792		6,695,792	0	6,695,792	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,881,544		11,881,544	0	11,881,544	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,753,538		7,753,538	0	7,753,538	73.00
74.00	07400	RENAL DIALYSIS	102,675		102,675	0	102,675	74.00
76.00	03950	SLEEP LAB	706,485		706,485	0	706,485	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	566,853		566,853	0	566,853	90.00
91.00	09100	EMERGENCY	3,687,847		3,687,847	0	3,687,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,992,755		1,992,755		1,992,755	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	92,964,957	0	92,964,957	0	92,964,957	200.00
201.00		Less Observation Beds	1,992,755		1,992,755		1,992,755	201.00
202.00		Total (see instructions)	90,972,202	0	90,972,202	0	90,972,202	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part I Date/Time Prepared: 8/31/2016 2:08 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,459,053		29,459,053			30.00
31.00	03100	INTENSIVE CARE UNIT	4,467,572		4,467,572			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	26,620,810		26,620,810			31.01
43.00	04300	NURSERY	7,489,065		7,489,065			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,627,999	146,244,234	190,872,233	0.103042	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,243,630	0	13,243,630	0.264301	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,426,947	38,477,274	45,904,221	0.092443	0.000000	54.00
54.01	05401	ULTRA SOUND	3,364,891	11,116,526	14,481,417	0.046038	0.000000	54.01
56.00	05600	RADIOISOTOPE	421,060	3,005,369	3,426,429	0.088435	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	794,395	10,851,515	11,645,910	0.048475	0.000000	58.00
60.00	06000	LABORATORY	22,223,397	27,708,721	49,932,118	0.078843	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,630,400	1,473,134	9,103,534	0.180555	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,078,593	259,485	2,338,078	0.225021	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	617,241	2,147,308	2,764,549	0.107078	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,237,587	30,349,387	40,586,974	0.164974	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,757,769	34,565,629	67,323,398	0.176485	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,891,502	33,039,826	66,931,328	0.115843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	399,620	23,075	422,695	0.242906	0.000000	74.00
76.00	03950	SLEEP LAB	109,637	3,325,117	3,434,754	0.205687	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	69,285	2,417,048	2,486,333	0.227988	0.000000	90.00
91.00	09100	EMERGENCY	5,311,889	30,187,527	35,499,416	0.103885	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	776,458	4,294,215	5,070,673	0.392996	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	254,018,800	379,485,390	633,504,190			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	254,018,800	379,485,390	633,504,190			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part I Date/Time Prepared: 8/31/2016 2:08 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		31.01
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.103042	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.264301	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092443	54.00
54.01	05401	ULTRA SOUND	0.046038	54.01
56.00	05600	RADIOISOTOPE	0.088435	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.048475	58.00
60.00	06000	LABORATORY	0.078843	60.00
65.00	06500	RESPIRATORY THERAPY	0.180555	65.00
66.00	06600	PHYSICAL THERAPY	0.225021	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107078	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.164974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.176485	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115843	73.00
74.00	07400	RENAL DIALYSIS	0.242906	74.00
76.00	03950	SLEEP LAB	0.205687	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.227988	90.00
91.00	09100	EMERGENCY	0.103885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.392996	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part I Date/Time Prepared: 8/31/2016 2:08 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,405,699		14,405,699	0	14,405,699	30.00
31.00	03100	INTENSIVE CARE UNIT	2,308,091		2,308,091	0	2,308,091	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	5,286,084		5,286,084	0	5,286,084	31.01
43.00	04300	NURSERY	2,229,014		2,229,014	0	2,229,014	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,667,880		19,667,880	0	19,667,880	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,500,310		3,500,310	0	3,500,310	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,243,507		4,243,507	0	4,243,507	54.00
54.01	05401	ULTRA SOUND	666,693		666,693	0	666,693	54.01
56.00	05600	RADIOISOTOPE	303,015		303,015	0	303,015	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	564,538		564,538	0	564,538	58.00
60.00	06000	LABORATORY	3,936,814		3,936,814	0	3,936,814	60.00
65.00	06500	RESPIRATORY THERAPY	1,643,685	0	1,643,685	0	1,643,685	65.00
66.00	06600	PHYSICAL THERAPY	526,117	0	526,117	0	526,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	296,021		296,021	0	296,021	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,695,792		6,695,792	0	6,695,792	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,881,544		11,881,544	0	11,881,544	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,753,538		7,753,538	0	7,753,538	73.00
74.00	07400	RENAL DIALYSIS	102,675		102,675	0	102,675	74.00
76.00	03950	SLEEP LAB	706,485		706,485	0	706,485	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	566,853		566,853	0	566,853	90.00
91.00	09100	EMERGENCY	3,687,847		3,687,847	0	3,687,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,992,755		1,992,755		1,992,755	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	92,964,957	0	92,964,957	0	92,964,957	200.00
201.00		Less Observation Beds	1,992,755		1,992,755		1,992,755	201.00
202.00		Total (see instructions)	90,972,202	0	90,972,202	0	90,972,202	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part I Date/Time Prepared: 8/31/2016 2:08 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,459,053		29,459,053			30.00
31.00	03100	INTENSIVE CARE UNIT	4,467,572		4,467,572			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	26,620,810		26,620,810			31.01
43.00	04300	NURSERY	7,489,065		7,489,065			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,627,999	146,244,234	190,872,233	0.103042	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,243,630	0	13,243,630	0.264301	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,426,947	38,477,274	45,904,221	0.092443	0.000000	54.00
54.01	05401	ULTRA SOUND	3,364,891	11,116,526	14,481,417	0.046038	0.000000	54.01
56.00	05600	RADIOISOTOPE	421,060	3,005,369	3,426,429	0.088435	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	794,395	10,851,515	11,645,910	0.048475	0.000000	58.00
60.00	06000	LABORATORY	22,223,397	27,708,721	49,932,118	0.078843	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,630,400	1,473,134	9,103,534	0.180555	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,078,593	259,485	2,338,078	0.225021	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	617,241	2,147,308	2,764,549	0.107078	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,237,587	30,349,387	40,586,974	0.164974	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,757,769	34,565,629	67,323,398	0.176485	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,891,502	33,039,826	66,931,328	0.115843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	399,620	23,075	422,695	0.242906	0.000000	74.00
76.00	03950	SLEEP LAB	109,637	3,325,117	3,434,754	0.205687	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	69,285	2,417,048	2,486,333	0.227988	0.000000	90.00
91.00	09100	EMERGENCY	5,311,889	30,187,527	35,499,416	0.103885	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	776,458	4,294,215	5,070,673	0.392996	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	254,018,800	379,485,390	633,504,190			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	254,018,800	379,485,390	633,504,190			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part I Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		31.01
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.103042	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.264301	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092443	54.00
54.01	05401	ULTRA SOUND	0.046038	54.01
56.00	05600	RADIOISOTOPE	0.088435	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.048475	58.00
60.00	06000	LABORATORY	0.078843	60.00
65.00	06500	RESPIRATORY THERAPY	0.180555	65.00
66.00	06600	PHYSICAL THERAPY	0.225021	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107078	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.164974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.176485	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115843	73.00
74.00	07400	RENAL DIALYSIS	0.242906	74.00
76.00	03950	SLEEP LAB	0.205687	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.227988	90.00
91.00	09100	EMERGENCY	0.103885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.392996	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part II Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,667,880	3,050,243	16,617,637	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,500,310	24,321	3,475,989	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,243,507	630,146	3,613,361	0	0	54.00
54.01	05401	ULTRA SOUND	666,693	4,944	661,749	0	0	54.01
56.00	05600	RADIOISOTOPE	303,015	1,663	301,352	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	564,538	115,188	449,350	0	0	58.00
60.00	06000	LABORATORY	3,936,814	155,191	3,781,623	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,643,685	11,457	1,632,228	0	0	65.00
66.00	06600	PHYSICAL THERAPY	526,117	41,752	484,365	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	296,021	2,351	293,670	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,695,792	61,706	6,634,086	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,881,544	113,085	11,768,459	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,753,538	115,138	7,638,400	0	0	73.00
74.00	07400	RENAL DIALYSIS	102,675	415	102,260	0	0	74.00
76.00	03950	SLEEP LAB	706,485	148,792	557,693	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	566,853	3,735	563,118	0	0	90.00
91.00	09100	EMERGENCY	3,687,847	539,278	3,148,569	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,992,755	461,905	1,530,850	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	68,736,069	5,481,310	63,254,759	0	0	200.00
201.00		Less Observation Beds	1,992,755	461,905	1,530,850	0	0	201.00
202.00		Total (line 200 minus line 201)	66,743,314	5,019,405	61,723,909	0	0	202.00

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

Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet C Part II | Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	19,667,880	190,872,233	0.103042		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,500,310	13,243,630	0.264301		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,243,507	45,904,221	0.092443		54.00
54.01	05401	ULTRA SOUND	666,693	14,481,417	0.046038		54.01
56.00	05600	RADIOISOTOPE	303,015	3,426,429	0.088435		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	564,538	11,645,910	0.048475		58.00
60.00	06000	LABORATORY	3,936,814	49,932,118	0.078843		60.00
65.00	06500	RESPIRATORY THERAPY	1,643,685	9,103,534	0.180555		65.00
66.00	06600	PHYSICAL THERAPY	526,117	2,338,078	0.225021		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	296,021	2,764,549	0.107078		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,695,792	40,586,974	0.164974		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,881,544	67,323,398	0.176485		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,753,538	66,931,328	0.115843		73.00
74.00	07400	RENAL DIALYSIS	102,675	422,695	0.242906		74.00
76.00	03950	SLEEP LAB	706,485	3,434,754	0.205687		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	566,853	2,486,333	0.227988		90.00
91.00	09100	EMERGENCY	3,687,847	35,499,416	0.103885		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,992,755	5,070,673	0.392996		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
200.00		Subtotal (sum of lines 50 thru 199)	68,736,069	565,467,690			200.00
201.00		Less Observation Beds	1,992,755	0			201.00
202.00		Total (line 200 minus line 201)	66,743,314	565,467,690			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part I Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,339,125	0	3,339,125	13,981	238.83	30.00
31.00	INTENSIVE CARE UNIT	456,496		456,496	1,072	425.84	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	661,622		661,622	5,477	120.80	31.01
43.00	NURSERY	212,019		212,019	4,848	43.73	43.00
200.00	Total (lines 30-199)	4,669,262		4,669,262	25,378		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	2,086	498,199	30.00
31.00	INTENSIVE CARE UNIT	446	189,925	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	2,532	688,124	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part II Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,050,243	190,872,233	0.015981	6,639,356	106,104	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,321	13,243,630	0.001836	29,870	55	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	630,146	45,904,221	0.013727	2,327,089	31,944	54.00
54.01	05401	ULTRA SOUND	4,944	14,481,417	0.000341	987,379	337	54.01
56.00	05600	RADIOISOTOPE	1,663	3,426,429	0.000485	173,879	84	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	115,188	11,645,910	0.009891	274,648	2,717	58.00
60.00	06000	LABORATORY	155,191	49,932,118	0.003108	4,877,994	15,161	60.00
65.00	06500	RESPIRATORY THERAPY	11,457	9,103,534	0.001259	1,656,981	2,086	65.00
66.00	06600	PHYSICAL THERAPY	41,752	2,338,078	0.017857	595,835	10,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,351	2,764,549	0.000850	256,971	218	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,706	40,586,974	0.001520	2,153,908	3,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,085	67,323,398	0.001680	7,779,764	13,070	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,138	66,931,328	0.001720	6,936,797	11,931	73.00
74.00	07400	RENAL DIALYSIS	415	422,695	0.000982	138,021	136	74.00
76.00	03950	SLEEP LAB	148,792	3,434,754	0.043320	36,653	1,588	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,735	2,486,333	0.001502	29,275	44	90.00
91.00	09100	EMERGENCY	539,278	35,499,416	0.015191	1,716,028	26,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	461,905	5,070,673	0.091093	364,203	33,176	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,481,310	565,467,690		36,974,651	258,633	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part III Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0		0	31.01
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,981	0.00	2,086	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,072	0.00	446	0		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	5,477	0.00	0	0		31.01
43.00	04300	NURSERY	4,848	0.00	0	0		43.00
200.00		Total (lines 30-199)	25,378		2,532	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part IV | Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part IV | Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	190,872,233	0.000000	0.000000	6,639,356	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,243,630	0.000000	0.000000	29,870	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,904,221	0.000000	0.000000	2,327,089	54.00
54.01	05401	ULTRA SOUND	0	14,481,417	0.000000	0.000000	987,379	54.01
56.00	05600	RADIOISOTOPE	0	3,426,429	0.000000	0.000000	173,879	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	11,645,910	0.000000	0.000000	274,648	58.00
60.00	06000	LABORATORY	0	49,932,118	0.000000	0.000000	4,877,994	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,103,534	0.000000	0.000000	1,656,981	65.00
66.00	06600	PHYSICAL THERAPY	0	2,338,078	0.000000	0.000000	595,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,764,549	0.000000	0.000000	256,971	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	40,586,974	0.000000	0.000000	2,153,908	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,323,398	0.000000	0.000000	7,779,764	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	66,931,328	0.000000	0.000000	6,936,797	73.00
74.00	07400	RENAL DIALYSIS	0	422,695	0.000000	0.000000	138,021	74.00
76.00	03950	SLEEP LAB	0	3,434,754	0.000000	0.000000	36,653	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,486,333	0.000000	0.000000	29,275	90.00
91.00	09100	EMERGENCY	0	35,499,416	0.000000	0.000000	1,716,028	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,070,673	0.000000	0.000000	364,203	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	565,467,690			36,974,651	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part IV Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	22,420,265	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,768,420	0		54.00
54.01	05401	ULTRA SOUND	0	1,613,581	0		54.01
56.00	05600	RADIOISOTOPE	0	754,783	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	1,776,879	0		58.00
60.00	06000	LABORATORY	0	2,699,551	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	308,762	0		65.00
66.00	06600	PHYSICAL THERAPY	0	7,663	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	404,703	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,853,699	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,156,191	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,607,647	0		73.00
74.00	07400	RENAL DIALYSIS	0	15,410	0		74.00
76.00	03950	SLEEP LAB	0	620,467	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	586,704	0		90.00
91.00	09100	EMERGENCY	0	3,354,933	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	587,560	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	64,537,218	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part V Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.103042	22,420,265	0	0	2,310,229	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.264301	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092443	6,768,420	0	0	625,693	54.00
54.01	05401	ULTRA SOUND	0.046038	1,613,581	0	0	74,286	54.01
56.00	05600	RADIOISOTOPE	0.088435	754,783	0	0	66,749	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.048475	1,776,879	0	0	86,134	58.00
60.00	06000	LABORATORY	0.078843	2,699,551	0	0	212,841	60.00
65.00	06500	RESPIRATORY THERAPY	0.180555	308,762	0	0	55,749	65.00
66.00	06600	PHYSICAL THERAPY	0.225021	7,663	0	0	1,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107078	404,703	0	0	43,335	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.164974	5,853,699	0	0	965,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.176485	9,156,191	0	0	1,615,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115843	7,607,647	0	14,284	881,293	73.00
74.00	07400	RENAL DIALYSIS	0.242906	15,410	0	0	3,743	74.00
76.00	03950	SLEEP LAB	0.205687	620,467	0	0	127,622	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.227988	586,704	0	0	133,761	90.00
91.00	09100	EMERGENCY	0.103885	3,354,933	0	0	348,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.392996	587,560	0	0	230,909	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		64,537,218	0	14,284	7,784,233	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		64,537,218	0	14,284	7,784,233	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part V Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,655		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,655		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,655		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part I Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,339,125	0	3,339,125	13,981	238.83	30.00
31.00	INTENSIVE CARE UNIT	456,496		456,496	1,072	425.84	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	661,622		661,622	5,477	120.80	31.01
43.00	NURSERY	212,019		212,019	4,848	43.73	43.00
200.00	Total (lines 30-199)	4,669,262		4,669,262	25,378		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	219	52,304	30.00
31.00	INTENSIVE CARE UNIT	30	12,775	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	473	57,138	31.01
43.00	NURSERY	205	8,965	43.00
200.00	Total (lines 30-199)	927	131,182	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part II Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,050,243	190,872,233	0.015981	579,915	9,268	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,321	13,243,630	0.001836	189,046	347	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	630,146	45,904,221	0.013727	189,012	2,595	54.00
54.01	05401	ULTRA SOUND	4,944	14,481,417	0.000341	143,842	49	54.01
56.00	05600	RADIOISOTOPE	1,663	3,426,429	0.000485	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	115,188	11,645,910	0.009891	12,882	127	58.00
60.00	06000	LABORATORY	155,191	49,932,118	0.003108	829,710	2,579	60.00
65.00	06500	RESPIRATORY THERAPY	11,457	9,103,534	0.001259	468,957	590	65.00
66.00	06600	PHYSICAL THERAPY	41,752	2,338,078	0.017857	53,130	949	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,351	2,764,549	0.000850	8,454	7	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,706	40,586,974	0.001520	215,234	327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,085	67,323,398	0.001680	53,119	89	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,138	66,931,328	0.001720	1,135,959	1,954	73.00
74.00	07400	RENAL DIALYSIS	415	422,695	0.000982	28,096	28	74.00
76.00	03950	SLEEP LAB	148,792	3,434,754	0.043320	3,967	172	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,735	2,486,333	0.001502	5,506	8	90.00
91.00	09100	EMERGENCY	539,278	35,499,416	0.015191	100,917	1,533	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	461,905	5,070,673	0.091093	16,026	1,460	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,481,310	565,467,690		4,033,772	22,082	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part III Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0		0	31.01
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,981	0.00	219	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,072	0.00	30	0		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	5,477	0.00	473	0		31.01
43.00	04300	NURSERY	4,848	0.00	205	0		43.00
200.00		Total (lines 30-199)	25,378		927	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part IV | Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part IV | Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | 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	190,872,233	0.000000	0.000000	579,915	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,243,630	0.000000	0.000000	189,046	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,904,221	0.000000	0.000000	189,012	54.00
54.01	05401	ULTRA SOUND	0	14,481,417	0.000000	0.000000	143,842	54.01
56.00	05600	RADIOISOTOPE	0	3,426,429	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	11,645,910	0.000000	0.000000	12,882	58.00
60.00	06000	LABORATORY	0	49,932,118	0.000000	0.000000	829,710	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,103,534	0.000000	0.000000	468,957	65.00
66.00	06600	PHYSICAL THERAPY	0	2,338,078	0.000000	0.000000	53,130	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,764,549	0.000000	0.000000	8,454	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	40,586,974	0.000000	0.000000	215,234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,323,398	0.000000	0.000000	53,119	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	66,931,328	0.000000	0.000000	1,135,959	73.00
74.00	07400	RENAL DIALYSIS	0	422,695	0.000000	0.000000	28,096	74.00
76.00	03950	SLEEP LAB	0	3,434,754	0.000000	0.000000	3,967	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,486,333	0.000000	0.000000	5,506	90.00
91.00	09100	EMERGENCY	0	35,499,416	0.000000	0.000000	100,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,070,673	0.000000	0.000000	16,026	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	565,467,690			4,033,772	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part IV Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | 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	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part V Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.103042	0	0	1,021,392	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.264301	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092443	0	0	473,718	0	54.00
54.01	05401	ULTRA SOUND	0.046038	0	0	150,168	0	54.01
56.00	05600	RADIOISOTOPE	0.088435	0	0	15,528	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.048475	0	0	86,612	0	58.00
60.00	06000	LABORATORY	0.078843	0	0	406,231	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.180555	0	0	21,423	0	65.00
66.00	06600	PHYSICAL THERAPY	0.225021	0	0	2,755	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107078	0	0	32,370	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.164974	0	0	278,219	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.176485	0	0	297,249	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115843	0	0	313,280	0	73.00
74.00	07400	RENAL DIALYSIS	0.242906	0	0	6,349	0	74.00
76.00	03950	SLEEP LAB	0.205687	0	0	63,352	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.227988	0	0	6,864	0	90.00
91.00	09100	EMERGENCY	0.103885	0	0	818,205	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.392996	0	0	67,430	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	4,061,145	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	4,061,145	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D Part V Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	105,246		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,792		54.00
54.01	05401	ULTRA SOUND	0	6,913		54.01
56.00	05600	RADIOISOTOPE	0	1,373		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	4,199		58.00
60.00	06000	LABORATORY	0	32,028		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,868		65.00
66.00	06600	PHYSICAL THERAPY	0	620		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,466		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	45,899		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,460		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	36,291		73.00
74.00	07400	RENAL DIALYSIS	0	1,542		74.00
76.00	03950	SLEEP LAB	0	13,031		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	1,565		90.00
91.00	09100	EMERGENCY	0	84,999		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	26,500		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	463,792		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	463,792		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-1 | Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,981	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,981	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)	12,047	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)	2,086	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)	14,405,699	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)	14,405,699	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)	14,405,699	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)	1,030.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,149,373	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,149,373	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-1 | Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,308,091	1,072	2,153.07	446	960,269	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	5,286,084	5,477	965.14	0	0	43.01
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)	4,727,731	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,837,373	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)	688,124	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	258,633	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	946,757	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,890,616	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)	1,934	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,030.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,992,755	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-1 | Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,339,125	14,405,699	0.231792	1,992,755	461,905	90.00
91.00	Nursing School cost	0	14,405,699	0.000000	1,992,755	0	91.00
92.00	Allied health cost	0	14,405,699	0.000000	1,992,755	0	92.00
93.00	All other Medical Education	0	14,405,699	0.000000	1,992,755	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-1 | Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,981	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,981	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)	12,047	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)	219	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)	4,848	15.00
16.00	Nursery days (title V or XIX only)	205	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)	14,405,699	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)	14,405,699	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)	14,405,699	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)	1,030.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	225,653	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)	225,653	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-1 | Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | 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)	2,229,014	4,848	459.78	205	94,255	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,308,091	1,072	2,153.07	30	64,592	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	5,286,084	5,477	965.14	473	456,511	43.01
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)	499,544	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,340,555	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)	131,182	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	22,082	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	153,264	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,187,291	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)	1,934	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,030.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,992,755	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-1 | Date/Time Prepared: 8/31/2016 2:08 pm

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,339,125	14,405,699	0.231792	1,992,755	461,905	90.00
91.00	Nursing School cost	0	14,405,699	0.000000	1,992,755	0	91.00
92.00	Allied health cost	0	14,405,699	0.000000	1,992,755	0	92.00
93.00	All other Medical Education	0	14,405,699	0.000000	1,992,755	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-3 | Date/Time Prepared: 8/31/2016 2:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,723,718		30.00
31.00	03100	INTENSIVE CARE UNIT		1,877,600		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.103042	6,639,356	684,133	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.264301	29,870	7,895	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092443	2,327,089	215,123	54.00
54.01	05401	ULTRA SOUND	0.046038	987,379	45,457	54.01
56.00	05600	RADIOISOTOPE	0.088435	173,879	15,377	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.048475	274,648	13,314	58.00
60.00	06000	LABORATORY	0.078843	4,877,994	384,596	60.00
65.00	06500	RESPIRATORY THERAPY	0.180555	1,656,981	299,176	65.00
66.00	06600	PHYSICAL THERAPY	0.225021	595,835	134,075	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107078	256,971	27,516	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.164974	2,153,908	355,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.176485	7,779,764	1,373,012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115843	6,936,797	803,579	73.00
74.00	07400	RENAL DIALYSIS	0.242906	138,021	33,526	74.00
76.00	03950	SLEEP LAB	0.205687	36,653	7,539	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.227988	29,275	6,674	90.00
91.00	09100	EMERGENCY	0.103885	1,716,028	178,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.392996	364,203	143,130	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		36,974,651	4,727,731	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)		36,974,651		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet D-3 | Date/Time Prepared: 8/31/2016 2:08 pm

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		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		473,699		30.00
31.00	03100	INTENSIVE CARE UNIT		125,758		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		2,352,458		31.01
43.00	04300	NURSERY		312,524		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.103042	579,915	59,756	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.264301	189,046	49,965	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092443	189,012	17,473	54.00
54.01	05401	ULTRA SOUND	0.046038	143,842	6,622	54.01
56.00	05600	RADIOISOTOPE	0.088435	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.048475	12,882	624	58.00
60.00	06000	LABORATORY	0.078843	829,710	65,417	60.00
65.00	06500	RESPIRATORY THERAPY	0.180555	468,957	84,673	65.00
66.00	06600	PHYSICAL THERAPY	0.225021	53,130	11,955	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107078	8,454	905	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.164974	215,234	35,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.176485	53,119	9,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115843	1,135,959	131,593	73.00
74.00	07400	RENAL DIALYSIS	0.242906	28,096	6,825	74.00
76.00	03950	SLEEP LAB	0.205687	3,967	816	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.227988	5,506	1,255	90.00
91.00	09100	EMERGENCY	0.103885	100,917	10,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.392996	16,026	6,298	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		4,033,772	499,544	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)		4,033,772		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part A Date/Time Prepared: 8/31/2016 2:08 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,617,533	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,010,405	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)	236,356	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	3,301,333	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	125.72	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.32	30.00
31.00	Percentage of Medicaid patient days (see instructions)	32.44	31.00
32.00	Sum of lines 30 and 31	35.76	32.00
33.00	Allowable disproportionate share percentage (see instructions)	18.72	33.00
34.00	Disproportionate share adjustment (see instructions)	263,388	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part A Date/Time Prepared: 8/31/2016 2:08 pm
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000180268	0.000177496	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,378,624	1,137,064	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	691,201	568,532	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,259,733		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		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,387,415		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	7,387,415	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	550,841	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	1,036	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)	7,939,292	59.00
60.00	Primary payer payments	11,935	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	7,927,357	61.00
62.00	Deductibles billed to program beneficiaries	706,860	62.00
63.00	Coinsurance billed to program beneficiaries	2,527	63.00
64.00	Allowable bad debts (see instructions)	114,273	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	74,277	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,317	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,292,247	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00		0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	18,063	70.93
70.94	HRR adjustment amount (see instructions)	-10,039	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part A Date/Time Prepared: 8/31/2016 2:08 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		38,248	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,262,023	71.00
71.01	Sequestration adjustment (see instructions)		145,240	71.01
72.00	Interim payments		7,184,508	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)		-67,725	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,177,296	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/31/2016 2:08 pm

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	2,617,533	2,617,533		2,617,533	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,010,405		3,010,405	3,010,405	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	236,356	133,698	102,658	236,356	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	3,301,333	1,650,667	1,650,666	3,301,333	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	0.1872	0.1872	0.1872		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	263,388	122,501	140,887	263,388	11.00
11.01	Uncompensated care payments	36.00	1,259,733	691,201	568,532	1,259,733	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	7,387,415	3,564,933	3,822,482	7,387,415	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	7,387,415	3,564,933	3,822,482	7,387,415	15.00
16.00	Payment for inpatient program capital	50.00	550,841	259,294	291,547	550,841	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	0	1,036	1,036	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			3,824,227	4,115,065	7,939,292	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/31/2016 2:08 pm

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	447,497	208,305	239,192	447,497	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	69,737	35,345	34,392	69,737	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	0.0751	0.0751	0.0751		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	33,607	15,644	17,963	33,607	25.00
26.00	Total prospective capital payments (see instructions)	12.00	550,841	259,294	291,547	550,841	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	18,063	7,921	10,142	18,063	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	-10,039	-7,329	-2,710	-10,039	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		38,248	0	38,248	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part B Date/Time Prepared: 8/31/2016 2:08 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,655	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,784,233	2.00
3.00	PPS payments	7,724,895	3.00
4.00	Outlier payment (see instructions)	171,283	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)	1,655	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	14,284	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)	14,284	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)	14,284	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	12,629	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)	1,655	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	7,896,178	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)	1,378,957	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)	6,518,876	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)	6,518,876	30.00
31.00	Primary payer payments	3,597	31.00
32.00	Subtotal (line 30 minus line 31)	6,515,279	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)	310,783	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	202,009	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	183,929	36.00
37.00	Subtotal (see instructions)	6,717,288	37.00
38.00	MSP-LCC reconciliation amount from PS&R	68	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)	6,717,220	40.00
40.01	Sequestration adjustment (see instructions)	134,344	40.01
41.00	Interim payments	6,470,094	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	112,782	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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 8/31/2016 2:08 pm

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		7,184,508		6,470,094	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,184,508		6,470,094	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		0		112,782	6.01
6.02	SETTLEMENT TO PROGRAM		67,725		0	6.02
7.00	Total Medicare program liability (see instructions)		7,116,783		6,582,876	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet E-1 Part II Date/Time Prepared: 8/31/2016 2:08 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	5,200	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,532	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,569	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	18,596	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	633,504,190	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	526,506	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet E-3 Part VII | Date/Time Prepared: 8/31/2016 2:08 pm

Title XIX | Hospital | PPS

		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	0		1.00
2.00	Medical and other services		463,792	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	463,792	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)	0	463,792	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	3,264,439		8.00
9.00	Ancillary service charges	4,033,772	4,061,145	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)	7,298,211	4,061,145	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)	7,298,211	4,061,145	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,298,211	3,597,353	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)	0	463,792	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)	0	463,792	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)	0	463,792	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)	0	463,792	36.00
37.00	ELIMINATE SETTLEMENT	0	-463,792	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	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: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet G | Date/Time Prepared: 8/31/2016 2:08 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-154,667	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	26,504,158	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	1,095,338	0	0	0	6.00
7.00	Inventory	3,207,277	0	0	0	7.00
8.00	Prepaid expenses	1,046,643	0	0	0	8.00
9.00	Other current assets	-153,170	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)	31,545,579	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,060,000	0	0	0	12.00
13.00	Land improvements	629,378	0	0	0	13.00
14.00	Accumulated depreciation	-278,777	0	0	0	14.00
15.00	Buildings	63,592,215	0	0	0	15.00
16.00	Accumulated depreciation	-11,089,281	0	0	0	16.00
17.00	Leasehold improvements	3,585,945	0	0	0	17.00
18.00	Accumulated depreciation	-719,131	0	0	0	18.00
19.00	Fixed equipment	2,055,701	0	0	0	19.00
20.00	Accumulated depreciation	-1,003,006	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	-10,362	0	0	0	22.00
23.00	Major movable equipment	32,150,524	0	0	0	23.00
24.00	Accumulated depreciation	-24,871,118	0	0	0	24.00
25.00	Minor equipment depreciable	7,095,489	0	0	0	25.00
26.00	Accumulated depreciation	-6,042,738	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)	66,154,839	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	4,366,470	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,366,470	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	102,066,888	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,103,299	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,686,464	0	0	0	38.00
39.00	Payroll taxes payable	25,288	0	0	0	39.00
40.00	Notes and loans payable (short term)	123,200	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	-250,098,000	0	0	0	43.00
44.00	Other current liabilities	2,031,591	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-240,128,158	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	194,434	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	43,300,869	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	43,495,303	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-196,632,855	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	298,699,743				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)	298,699,743	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	102,066,888	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet G-1 | Date/Time Prepared: 8/31/2016 2:08 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		259,298,619		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		39,401,130				2.00
3.00	Total (sum of line 1 and line 2)		298,699,749		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		298,699,749		0		11.00
12.00	ROUNDING	6		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		6		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		298,699,743		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	ROUNDING		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 150150 | Period: From 04/01/2015 To 03/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/31/2016 2:08 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	36,948,118		36,948,118	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)	36,948,118		36,948,118	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,467,572		4,467,572	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	26,620,810		26,620,810	11.01
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)	31,088,382		31,088,382	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	68,036,500		68,036,500	17.00
18.00	Ancillary services	179,824,668	342,586,600	522,411,268	18.00
19.00	Outpatient services	6,157,632	36,898,790	43,056,422	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	0	0	0	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)	254,018,800	379,485,390	633,504,190	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		113,975,376		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)		113,975,376		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet G-3 Date/Time Prepared: 8/31/2016 2:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	633,504,190	1.00
2.00	Less contractual allowances and discounts on patients' accounts	481,129,433	2.00
3.00	Net patient revenues (line 1 minus line 2)	152,374,757	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	113,975,376	4.00
5.00	Net income from service to patients (line 3 minus line 4)	38,399,381	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISCELLANEOUS REVENUE	1,001,749	24.00
24.01		0	24.01
24.02		0	24.02
24.03		0	24.03
25.00	Total other income (sum of lines 6-24)	1,001,749	25.00
26.00	Total (line 5 plus line 25)	39,401,130	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)	39,401,130	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150150	Period: From 04/01/2015 To 03/31/2016	Worksheet L Parts I-III Date/Time Prepared: 8/31/2016 2:08 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	447,497	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	69,737	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)	53.50	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.32	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	32.44	8.00
9.00	Sum of lines 7 and 8	35.76	9.00
10.00	Allowable disproportionate share percentage (see instructions)	7.51	10.00
11.00	Disproportionate share adjustment (see instructions)	33,607	11.00
12.00	Total prospective capital payments (see instructions)	550,841	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