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: 150010	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/22/2016 2:42 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/22/2016 Time: 2:42 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPH HOSPITAL & HEALTH CENTER (150010) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	88,053	115,914	25,649	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	12,512	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	100,565	115,914	25,649	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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2016 2:42 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1907 WEST SYCAMORE STREET	PO Box:			1.00
2.00	City: KOKOMO	State: IN	Zip Code: 46901	County: HOWARD	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. JOSEPH HOSPITAL & HEALTH CENTER	150010	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ST. JOSEPH ACUTE REHAB	15T010	29020	5	07/01/2002	N	P	O	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
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	06/30/2016	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	553	327	0	8	4,451	4	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.	55	0	0	0	158		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2016 2:42 pm

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2016 2:42 pm

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	417,040	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2016 2:42 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15HO46	140.00

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	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
161.10	CORF		N	N	N	161.10

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150010	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 2:42 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)	07/01/2015	12/31/2015	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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2016 2:42 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/03/2016	Y	10/03/2016	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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2016 2:42 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	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.	RONALD	HELMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3234	RONALD.HELMS@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150010	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/22/2016 2:42 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2016 2:42 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	94	34,404	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)		94	34,404	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	13	4,758	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		107	39,162	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,588		0	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	101.00				0	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	99.00				0	25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		125				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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2016 2:42 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)	8,064	416	17,645			1.00
2.00	HMO and other (see instructions)	1,592	4,451				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	293	158				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)	8,064	416	17,645			7.00
8.00	INTENSIVE CARE UNIT	1,497	196	2,331			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		280	1,974			13.00
14.00	Total (see instructions)	9,561	892	21,950	0.00	652.04	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,780	55	3,553	0.00	21.19	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	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
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	673.23	27.00
28.00	Observation Bed Days		0	735			28.00
29.00	Ambulance Trips	2,286					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	445			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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2016 2:42 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	2,063	302	6,006	1.00
2.00	HMO and other (see instructions)			3	1,487		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				22		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,063	302	6,006	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	249	10	324	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	0.00					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	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 11/22/2016 2:42 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	40,068,557	0	40,068,557	1,400,323.00	28.61	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		304,009	0	304,009	2,091.00	145.39	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)		2,218,616	270,739	2,489,355	60,372.00	41.23	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		191,702	0	191,702	3,285.00	58.36	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		229,561	0	229,561	4,752.00	48.31	13.00
14.00	Home office salaries & wage-related costs		13,273,126	0	13,273,126	281,936.00	47.08	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)		12,490,602	0	12,490,602			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		691,611	0	691,611			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		94,769	0	94,769			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	89,585	0	89,585	8,258.00	10.85	26.00
27.00	Administrative & General	5.00	8,145,951	0	8,145,951	250,248.00	32.55	27.00
28.00	Administrative & General under contract (see inst.)		122,527	0	122,527	569.00	215.34	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	280,066	0	280,066	15,039.00	18.62	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,507,475	0	1,507,475	70,898.00	21.26	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		497,941	0	497,941	20,312.00	24.51	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	761,326	0	761,326	22,140.00	34.39	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,489,154	0	1,489,154	36,501.00	40.80	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 11/22/2016 2:42 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	531,540	0	531,540	36,401.00	14.60	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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 11/22/2016 2:42 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)		41,892,491	0	41,892,491	1,490,011.00	28.12	1.00
2.00	Excluded area salaries (see instructions)		2,218,616	270,739	2,489,355	60,372.00	41.23	2.00
3.00	Subtotal salaries (line 1 minus line 2)		39,673,875	-270,739	39,403,136	1,429,639.00	27.56	3.00
4.00	Subtotal other wages & related costs (see inst.)		13,694,389	0	13,694,389	289,973.00	47.23	4.00
5.00	Subtotal wage-related costs (see inst.)		12,490,602	0	12,490,602	0.00	31.70	5.00
6.00	Total (sum of lines 3 thru 5)		65,858,866	-270,739	65,588,127	1,719,612.00	38.14	6.00
7.00	Total overhead cost (see instructions)		13,425,565	0	13,425,565	460,366.00	29.16	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part IV | Date/Time Prepared: 11/22/2016 2:42 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,084,618	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)	476,610	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)	4,906,837	8.00
9.00	Prescription Drug Plan	1,167,961	9.00
10.00	Dental, Hearing and Vision Plan	90,703	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	30,669	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	317,166	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	32,154	14.00
15.00	'Workers' Compensation Insurance	380,598	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,944,208	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	50	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	59,028	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,490,602	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 11/22/2016 2:42 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	191,702	12,490,602	1.00
2.00	Hospital	191,702	12,490,602	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	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	0	0	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	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/22/2016 2:42 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)	0.250416	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,938,807	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	68,723,240	6.00
7.00	Medicaid cost (line 1 times line 6)	17,209,399	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)	10,270,592	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	10,270,592	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	6,932,236	3,855,706	10,787,942	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,735,943	965,530	2,701,473	21.00
22.00	Partial payment by patients approved for charity care	200,028	50,516	250,544	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,535,915	915,014	2,450,929	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)	7,599,209	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	342,518	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	7,256,691	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,817,192	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,268,121	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	14,538,713	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/22/2016 2:42 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		4,926,053	4,926,053	1,442,174	6,368,227	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	89,585	7,842,656	7,932,241	-9,400	7,922,841	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,145,951	18,655,127	26,801,078	-174,960	26,626,118	5.00
7.00	00700	OPERATION OF PLANT	280,066	5,992,582	6,272,648	-6,707	6,265,941	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	544,032	544,032	8.00
9.00	00900	HOUSEKEEPING	0	2,255,851	2,255,851	-488,603	1,767,248	9.00
10.00	01000	DIETARY	0	2,544,616	2,544,616	-1,854,718	689,898	10.00
11.00	01100	CAFETERIA	0	0	0	1,853,959	1,853,959	11.00
13.00	01300	NURSING ADMINISTRATION	761,326	225,470	986,796	-104,920	881,876	13.00
15.00	01500	PHARMACY	1,489,154	4,323,198	5,812,352	11,989,076	17,801,428	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	531,540	564,439	1,095,979	-3,996	1,091,983	16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	84,966	19,401	104,367	291,412	395,779	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,276,676	1,077,132	7,353,808	144,331	7,498,139	30.00
31.00	03100	INTENSIVE CARE UNIT	1,425,779	281,130	1,706,909	-149,004	1,557,905	31.00
41.00	04100	SUBPROVIDER - IRF	1,154,831	139,097	1,293,928	-26,947	1,266,981	41.00
43.00	04300	NURSERY	0	0	0	433,994	433,994	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,681,169	7,775,988	11,457,157	-4,569,869	6,887,288	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,050,756	450,713	2,501,469	-1,435,324	1,066,145	52.00
53.00	05300	ANESTHESIOLOGY	0	20,572	20,572	0	20,572	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,512,879	1,232,707	2,745,586	-356,232	2,389,354	54.00
54.01	03630	ULTRA SOUND	325,304	72,053	397,357	-31,304	366,053	54.01
57.00	05700	CT SCAN	319,074	33,511	352,585	-3,137	349,448	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	285,984	61,950	347,934	-25,954	321,980	58.00
59.00	05900	CARDIAC CATHETERIZATION	69,217	114,400	183,617	-44,102	139,515	59.00
60.00	06000	LABORATORY	0	5,853,083	5,853,083	-104,128	5,748,955	60.00
65.00	06500	RESPIRATORY THERAPY	1,244,450	302,550	1,547,000	-25,139	1,521,861	65.00
66.00	06600	PHYSICAL THERAPY	3,073,351	1,069,838	4,143,189	-1,600,194	2,542,995	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	997,346	997,346	67.00
68.00	06800	SPEECH PATHOLOGY	0	177	177	232,821	232,998	68.00
69.00	06900	ELECTROCARDIOLOGY	887,086	360,191	1,247,277	-190,407	1,056,870	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	333,862	210,700	544,562	-90,307	454,255	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	252,574	460,645	713,219	1,978,112	2,691,331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,119,596	4,119,596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,606	3,606	73.00
74.00	07400	RENAL DIALYSIS	0	153,234	153,234	-3,111	150,123	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	1,398,356	304,241	1,702,597	-27,299	1,675,298	76.00
76.01	03480	ONCOLOGY	996,601	15,864,669	16,861,270	-11,810,287	5,050,983	76.01
76.02	03330	ENDOSCOPY	201,202	254,864	456,066	-68,787	387,279	76.02
76.03	03951	WOUND CARE	227,155	775,670	1,002,825	-78,694	924,131	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,990,844	529,580	2,520,424	-205,399	2,315,025	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	758,670	177,372	936,042	-36,165	899,877	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		505,365	505,365	-505,365	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,848,408	85,430,825	125,279,233	0	125,279,233	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	642,682	642,682	0	642,682	192.00
192.01	19201	ASC-MOB	0	12,799	12,799	0	12,799	192.01
192.02	19202	EDUCATION CENTER	0	12,935	12,935	0	12,935	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	14,861	14,861	0	14,861	194.01
194.02	07952	CLINIC OF HOPE	220,149	63,134	283,283	0	283,283	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	40,068,557	86,177,236	126,245,793	0	126,245,793	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/22/2016 2:42 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	-23,452	6,344,775		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	734,471	8,657,312		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	540,794	27,166,912		5.00
7.00	00700	OPERATION OF PLANT	-240,633	6,025,308		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	544,032		8.00
9.00	00900	HOUSEKEEPING	0	1,767,248		9.00
10.00	01000	DIETARY	-13,015	676,883		10.00
11.00	01100	CAFETERIA	-642,614	1,211,345		11.00
13.00	01300	NURSING ADMINISTRATION	0	881,876		13.00
15.00	01500	PHARMACY	-21,765	17,779,663		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-684	1,091,299		16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	0	395,779		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,073	7,496,066		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,557,905		31.00
41.00	04100	SUBPROVIDER - IRF	0	1,266,981		41.00
43.00	04300	NURSERY	0	433,994		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-8,000	6,879,288		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-69	1,066,076		52.00
53.00	05300	ANESTHESIOLOGY	0	20,572		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-45,582	2,343,772		54.00
54.01	03630	ULTRA SOUND	0	366,053		54.01
57.00	05700	CT SCAN	0	349,448		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-17	321,963		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	139,515		59.00
60.00	06000	LABORATORY	-2,010	5,746,945		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,521,861		65.00
66.00	06600	PHYSICAL THERAPY	-39,330	2,503,665		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	997,346		67.00
68.00	06800	SPEECH PATHOLOGY	0	232,998		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,056,870		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	454,255		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,691,331		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,119,596		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,606		73.00
74.00	07400	RENAL DIALYSIS	0	150,123		74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	-161,053	1,514,245		76.00
76.01	03480	ONCOLOGY	-95,744	4,955,239		76.01
76.02	03330	ENDOSCOPY	0	387,279		76.02
76.03	03951	WOUND CARE	0	924,131		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-47	2,314,978		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	899,877		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-20,823	125,258,410		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	642,682		192.00
192.01	19201	ASC-MOB	0	12,799		192.01
192.02	19202	EDUCATION CENTER	0	12,935		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	FOUNDATION	0	0		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	14,861		194.01
194.02	07952	CLINIC OF HOPE	0	283,283		194.02
194.03	07953	MARKETING	821,324	821,324		194.03
200.00		TOTAL (SUM OF LINES 118-199)	800,501	127,046,294		200.00

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - BUILDING RENTAL RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	383,933		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	383,933		
	B - EQUIPMENT RENTAL EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	417,271		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	TOTALS		0	417,271		
	C - DRUGS CHARGED TO PATIENTS					
1.00	PHARMACY	15.00	0	377,608		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS		0	377,608		
	D - REAL ESTATE TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	50,729		1.00
	TOTALS		0	50,729		
	E - LAUNDRY DEPARTMENT RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	544,032		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	544,032		
	F - CAPITAL INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	93,865		1.00
	TOTALS		0	93,865		
	G - CAFETERIA_DIETARY RECLASS					
1.00	CAFETERIA	11.00	0	1,853,959		1.00
	TOTALS		0	1,853,959		

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	H - MEDICAL SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,011,150	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	TOTALS		0	2,011,150	
	I - PT_OT_ST RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	739,815	257,531	1.00
2.00	SPEECH PATHOLOGY	68.00	157,276	54,748	2.00
	TOTALS		897,091	312,279	
	J - IMPLANTABLE SUPPLY RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,117,249	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	22,500	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	4,139,749	
	K - CHEMOTHERAPY PHARMACY RECLASS				
1.00	PHARMACY	15.00	0	11,729,187	1.00
	TOTALS		0	11,729,187	
	L - RADIOLOGY SCHOOL PRECEPTING RECLASS				
1.00	SCHOOL OF RADIOLOGY-ALLIED HEALTH	23.00	270,739	20,673	1.00
	TOTALS		270,739	20,673	
	M - LABOR AND DELIVERY ROOM RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	388,409	85,364	1.00
2.00	NURSERY	43.00	355,797	78,197	2.00
3.00	OPERATING ROOM	50.00	254,062	55,837	3.00
4.00	ULTRA SOUND	54.01	3,840	844	4.00
5.00	LABORATORY	60.00	20,056	4,408	5.00
6.00	RESPIRATORY THERAPY	65.00	18,457	4,056	6.00
7.00	SPEECH PATHOLOGY	68.00	17,050	3,747	7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	23,623	5,192	8.00
9.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	1,924	423	9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	2,956	650	10.00
	TOTALS		1,086,174	238,718	

RECLASSIFICATIONS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/22/2016 2:42 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	N - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	496,376	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,989	2.00
	TOTALS		0	505,365	
500.00	Grand Total: Increases		2,254,004	22,678,518	500.00

RECLASSIFICATIONS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/22/2016 2:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - BUILDING RENTAL RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,500	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,014	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	290,017	0		3.00
4.00	ELECTROENCEPHALOGRAPHY	70.00	0	58,168	0		4.00
5.00	BEHAVIORAL HEALTH SERVICES	76.00	0	27,234	0		5.00
	TOTALS		0	383,933			
	B - EQUIPMENT RENTAL EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,507	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	52,237	0		2.00
3.00	OPERATION OF PLANT	7.00	0	6,707	0		3.00
4.00	HOUSEKEEPING	9.00	0	323	0		4.00
5.00	DIETARY	10.00	0	327	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	102,400	0		6.00
7.00	PHARMACY	15.00	0	107,610	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,872	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	8,843	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	325	0		10.00
11.00	SUBPROVIDER - IRF	41.00	0	1,106	0		11.00
12.00	OPERATING ROOM	50.00	0	4,648	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,751	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,735	0		14.00
15.00	LABORATORY	60.00	0	1,429	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	46,758	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	7,050	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	1,106	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,886	0		19.00
20.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	35,978	0		20.00
21.00	ONCOLOGY	76.01	0	1,423	0		21.00
22.00	WOUND CARE	76.03	0	3,963	0		22.00
23.00	EMERGENCY	91.00	0	5,964	0		23.00
24.00	AMBULANCE SERVICES	95.00	0	323	0		24.00
	TOTALS		0	417,271			
	C - DRUGS CHARGED TO PATIENTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,609	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	21,416	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	6,268	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	496	0		4.00
5.00	OPERATING ROOM	50.00	0	65,394	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	9,194	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,409	0		7.00
8.00	CT SCAN	57.00	0	13	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	24,634	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	5,314	0		10.00
11.00	LABORATORY	60.00	0	6,013	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	854	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	15,095	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	166,941	0		14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,488	0		15.00
16.00	RENAL DIALYSIS	74.00	0	1,304	0		16.00
17.00	BEHAVIORAL HEALTH SERVICES	76.00	0	65	0		17.00
18.00	ONCOLOGY	76.01	0	2,385	0		18.00
19.00	ENDOSCOPY	76.02	0	3,042	0		19.00
20.00	WOUND CARE	76.03	0	7,250	0		20.00
21.00	EMERGENCY	91.00	0	6,896	0		21.00
22.00	AMBULANCE SERVICES	95.00	0	9,528	0		22.00
	TOTALS		0	377,608			
	D - REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,729	13		1.00
	TOTALS		0	50,729			
	E - LAUNDRY DEPARTMENT RECLASS						
1.00	HOUSEKEEPING	9.00	0	488,132	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,134	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	46,062	0		3.00
4.00	ELECTROENCEPHALOGRAPHY	70.00	0	8,704	0		4.00
	TOTALS		0	544,032			
	F - CAPITAL INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	93,865	12		1.00
	TOTALS		0	93,865			

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		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	G - CAFETERIA_DIETARY RECLASS					
1.00	DIETARY	10.00	0	1,853,959	0	1.00
	TOTALS		0	1,853,959		
	H - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	284	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,118	0	2.00
3.00	HOUSEKEEPING	9.00	0	148	0	3.00
4.00	DIETARY	10.00	0	432	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,520	0	5.00
6.00	PHARMACY	15.00	0	9,938	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	124	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	298,730	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	141,989	0	9.00
10.00	SUBPROVIDER - IRF	41.00	0	25,345	0	10.00
11.00	OPERATING ROOM	50.00	0	729,084	0	11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	99,331	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,391	0	13.00
14.00	ULTRA SOUND	54.01	0	35,988	0	14.00
15.00	CT SCAN	57.00	0	3,124	0	15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,320	0	16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	24,970	0	17.00
18.00	LABORATORY	60.00	0	121,150	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	32,600	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	22,316	0	20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	18,549	0	21.00
22.00	RENAL DIALYSIS	74.00	0	1,807	0	22.00
23.00	ONCOLOGY	76.01	0	77,262	0	23.00
24.00	ENDOSCOPY	76.02	0	64,287	0	24.00
25.00	WOUND CARE	76.03	0	42,186	0	25.00
26.00	EMERGENCY	91.00	0	191,875	0	26.00
27.00	AMBULANCE SERVICES	95.00	0	26,282	0	27.00
	TOTALS		0	2,011,150		
	I - PT_OT_ST RECLASS					
1.00	PHYSICAL THERAPY	66.00	897,091	312,279	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		897,091	312,279		
	J - IMPLANTABLE SUPPLY RECLASS					
1.00	PHARMACY	15.00	0	171	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	453	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	422	0	3.00
4.00	OPERATING ROOM	50.00	0	4,080,642	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	156	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	137	0	6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	13,818	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	40	0	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	44	0	9.00
10.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16,387	0	10.00
11.00	ONCOLOGY	76.01	0	30	0	11.00
12.00	ENDOSCOPY	76.02	0	1,458	0	12.00
13.00	WOUND CARE	76.03	0	25,295	0	13.00
14.00	EMERGENCY	91.00	0	664	0	14.00
15.00	AMBULANCE SERVICES	95.00	0	32	0	15.00
	TOTALS		0	4,139,749		
	K - CHEMOTHERAPY PHARMACY RECLASS					
1.00	ONCOLOGY	76.01	0	11,729,187	0	1.00
	TOTALS		0	11,729,187		
	L - RADIOLOGY SCHOOL PRECEPTING RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	270,739	20,673	0	1.00
	TOTALS		270,739	20,673		
	M - LABOR AND DELIVERY ROOM RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,086,174	238,718	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
	TOTALS		1,086,174	238,718		

RECLASSIFICATIONS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/22/2016 2:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	N - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	505,365	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	505,365			
500.00	Grand Total: Decreases		2,254,004	22,678,518			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/22/2016 2:42 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	722,779	0	0	0	0	1.00
2.00	Land Improvements	1,764,978	0	0	0	0	2.00
3.00	Buildings and Fixtures	55,107,232	777,309	0	777,309	18,987	3.00
4.00	Building Improvements	9,712,068	0	0	0	0	4.00
5.00	Fixed Equipment	21,774,546	0	0	0	0	5.00
6.00	Movable Equipment	36,998,569	1,518,934	0	1,518,934	18,985	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	126,080,172	2,296,243	0	2,296,243	37,972	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	126,080,172	2,296,243	0	2,296,243	37,972	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	722,779	0	1.00
2.00	Land Improvements	1,764,978	0	2.00
3.00	Buildings and Fixtures	55,865,554	0	3.00
4.00	Building Improvements	9,712,068	0	4.00
5.00	Fixed Equipment	21,774,546	0	5.00
6.00	Movable Equipment	38,498,518	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	128,338,443	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	128,338,443	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/22/2016 2:42 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	4,926,053	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	4,926,053	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	4,926,053		1.00
3.00	Total (sum of lines 1-2)	0	4,926,053		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2016 2:42 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	128,338,443	0	128,338,443	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	128,338,443	0	128,338,443	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	4,938,705	801,204	1.00
3.00	Total (sum of lines 1-2)	0	0	0	4,938,705	801,204	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	460,272	93,865	50,729	0	6,344,775	1.00
3.00	Total (sum of lines 1-2)	460,272	93,865	50,729	0	6,344,775	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/22/2016 2:42 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	*** Cost Center Deleted ***	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)	B	-9,540	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-683,091			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	7,203,612			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-642,614	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	B	-21,765	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-684	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-13,015	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	REHAB RECYCLING REVENUE	B	-40	PHYSICAL THERAPY	66.00	0	33.00
33.01	MISCELLANEOUS REVENUE	B	-1,863	ADULTS & PEDIATRICS	30.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/22/2016 2:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISCELLANEOUS REVENUE	B	-210	ADULTS & PEDIATRICS	30.00	0	33.02
33.03	MISCELLANEOUS REVENUE	B	-75,833	ONCOLOGY	76.01	0	33.03
33.04	MISCELLANEOUS REVENUE	B	-35,416	PHYSICAL THERAPY	66.00	0	33.04
33.05	MISCELLANEOUS REVENUE	B	-17,368	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	MISCELLANEOUS REVENUE	B	-2,010	LABORATORY	60.00	0	33.06
33.07	MISCELLANEOUS REVENUE	B	-637	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MISCELLANEOUS REVENUE	B	-1,710	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	MISCELLANEOUS REVENUE	B	-715	OPERATION OF PLANT	7.00	0	33.09
33.10	MISCELLANEOUS REVENUE	B	-4,333	OPERATION OF PLANT	7.00	0	33.10
33.11	MISCELLANEOUS REVENUE	B	-350	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PROVIDER TAX	A	-5,385,415	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	TELEVISON OFFSET ELECTRICITY	A	-3,430	OPERATION OF PLANT	7.00	0	33.13
33.14	TELEVISION OFFSET CABLE	A	-8,102	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	CHARITABLE CONTRIBUTIONS	A	-6,788	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	NON-ALLOWBLE MARKETING	A	-2,782	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	NON-ALLOWBLE MARKETING	A	-69	DELIVERY ROOM & LABOR ROOM	52.00	0	33.17
33.18	AHA DEPRECIATION	A	12,652	CAP REL COSTS-BLDG & FIXT	1.00	9	33.18
33.19	LOBBYING OFFSET	A	-2,413	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	RENTAL INCOME	B	-2,820	OPERATION OF PLANT	7.00	0	33.20
33.21	INCENTIVE PAY SALARIES	A	463,183	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	INCENTIVE PAY FICA	A	44,067	ADMINISTRATIVE & GENERAL	5.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		800,501				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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2016 2:42 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	7.00	OPERATION OF PLANT	TRIMEDIX CLINICAL ENGINEERIN	4,018,909	4,248,244	1.00
2.00	58.00	MAGNETIC RESONANCE IMAGING (	TRIMEDIX CLINICAL ENGINEERIN	289	306	2.00
3.00	66.00	PHYSICAL THERAPY	TRIMEDIX CLINICAL ENGINEERIN	2,243	2,371	3.00
4.00	91.00	EMERGENCY	TRIMEDIX CLINICAL ENGINEERIN	832	879	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	AH INTEREST EXPENSE CAPITAL	460,272	496,376	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	AH INTEREST EXPENSE A&G	8,335	8,989	4.02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH SELF INSURANCE	4,813,039	4,076,858	4.03
4.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGE BACK	1,431,096	1,431,096	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGE BACK	3,713,253	3,713,253	4.05
4.06	15.00	PHARMACY	SVH CHARGE BACK	-67,255	-67,255	4.06
4.07	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGE BACK	779,612	779,612	4.07
4.08	23.00	SCHOOL OF RADIOLOGY-ALLIED H	SVH CHARGE BACK	13,310	13,310	4.08
4.09	30.00	ADULTS & PEDIATRICS	SVH CHARGE BACK	225	225	4.09
4.10	52.00	DELIVERY ROOM & LABOR ROOM	SVH CHARGE BACK	25	25	4.10
4.11	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGE BACK	62,739	62,739	4.11
4.12	59.00	CARDIAC CATHETERIZATION	SVH CHARGE BACK	5,004	5,004	4.12
4.13	69.00	ELECTROCARDIOLOGY	SVH CHARGE BACK	51,992	51,992	4.13
4.14	76.01	ONCOLOGY	SVH CHARGE BACK	5,436	5,436	4.14
4.15	192.00	PHYSICIANS' PRIVATE OFFICES	SVH CHARGE BACK	560,904	560,904	4.15
4.16	194.02	CLINIC OF HOPE	SVH CHARGE BACK	-69	-69	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	SVH HOME OFFICE	14,591,077	8,678,685	4.17
4.18	194.03	MARKETING	SVH MARKETING	821,324	0	4.18
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			31,272,592	24,068,980	5.00

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

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

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

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

6.00	B		0.00	ASCENSION HEALH	100.00	6.00
7.00	B		0.00	STV HEALTH	100.00	7.00
8.00	A		0.00	TRIMEDX	0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2016 2:42 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	-229,335	0		1.00
2.00	-17	0		2.00
3.00	-128	0		3.00
4.00	-47	0		4.00
4.01	-36,104	11		4.01
4.02	-654	0		4.02
4.03	736,181	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	5,912,392	0		4.17
4.18	821,324	0		4.18
5.00	7,203,612			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOME OFFICE		7.00
8.00	CLINICAL ENGINE		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2016 2:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	DR. A	462,167	462,167	0	0	0	1.00
2.00	30.00	DR. B	65,000	0	65,000	181,300	2,640	2.00
3.00	50.00	DR. C	8,000	8,000	0	0	0	3.00
4.00	54.00	DR. D	28,214	28,214	0	0	0	4.00
5.00	60.00	DR. E	157,561	0	157,561	260,300	2,080	5.00
6.00	66.00	DR. F	7,000	0	7,000	211,500	32	6.00
7.00	76.00	DR. G	161,053	161,053	0	0	0	7.00
8.00	76.01	DR. H	19,911	19,911	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			908,906	679,345	229,561		4,752	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	DR. A	0	0	0	0	0	1.00
2.00	30.00	DR. B	230,112	11,506	0	0	0	2.00
3.00	50.00	DR. C	0	0	0	0	0	3.00
4.00	54.00	DR. D	0	0	0	0	0	4.00
5.00	60.00	DR. E	260,300	13,015	0	0	0	5.00
6.00	66.00	DR. F	3,254	163	0	0	0	6.00
7.00	76.00	DR. G	0	0	0	0	0	7.00
8.00	76.01	DR. H	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			493,666	24,684	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	DR. A	0	0	0	462,167		1.00
2.00	30.00	DR. B	0	230,112	0	0		2.00
3.00	50.00	DR. C	0	0	0	8,000		3.00
4.00	54.00	DR. D	0	0	0	28,214		4.00
5.00	60.00	DR. E	0	260,300	0	0		5.00
6.00	66.00	DR. F	0	3,254	3,746	3,746		6.00
7.00	76.00	DR. G	0	0	0	161,053		7.00
8.00	76.01	DR. H	0	0	0	19,911		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	493,666	3,746	683,091		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,344,775	6,344,775				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,657,312	245,420	8,902,732			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,166,912	1,013,611	1,813,997	29,994,520	29,994,520	5.00
7.00	00700	OPERATION OF PLANT	6,025,308	880,410	62,366	6,968,084	2,153,535	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	544,032	9,916	0	553,948	171,202	8.00
9.00	00900	HOUSEKEEPING	1,767,248	38,574	0	1,805,822	558,102	9.00
10.00	01000	DIETARY	676,883	99,642	0	776,525	239,990	10.00
11.00	01100	CAFETERIA	1,211,345	120,796	0	1,332,141	411,708	11.00
13.00	01300	NURSING ADMINISTRATION	881,876	50,271	169,536	1,101,683	340,483	13.00
15.00	01500	PHARMACY	17,779,663	61,240	331,612	18,172,515	5,616,329	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,091,299	46,844	118,366	1,256,509	388,333	16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	395,779	17,153	79,210	492,142	152,100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,496,066	563,662	1,484,214	9,543,942	2,949,622	30.00
31.00	03100	INTENSIVE CARE UNIT	1,557,905	107,893	317,500	1,983,298	612,952	31.00
41.00	04100	SUBPROVIDER - IRF	1,266,981	259,739	257,164	1,783,884	551,322	41.00
43.00	04300	NURSERY	433,994	30,802	79,231	544,027	168,135	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,879,288	619,714	876,317	8,375,319	2,588,451	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,066,076	62,484	214,798	1,343,358	415,174	52.00
53.00	05300	ANESTHESIOLOGY	20,572	5,303	0	25,875	7,997	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,343,772	494,305	276,606	3,114,683	962,615	54.00
54.01	03630	ULTRA SOUND	366,053	0	73,295	439,348	135,784	54.01
57.00	05700	CT SCAN	349,448	0	71,053	420,501	129,959	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	321,963	0	63,684	385,647	119,187	58.00
59.00	05900	CARDIAC CATHETERIZATION	139,515	7,657	15,414	162,586	50,248	59.00
60.00	06000	LABORATORY	5,746,945	151,234	4,466	5,902,645	1,824,254	60.00
65.00	06500	RESPIRATORY THERAPY	1,521,861	23,681	281,230	1,826,772	564,577	65.00
66.00	06600	PHYSICAL THERAPY	2,503,665	138,120	484,620	3,126,405	966,237	66.00
67.00	06700	OCCUPATIONAL THERAPY	997,346	59,268	164,746	1,221,360	377,470	67.00
68.00	06800	SPEECH PATHOLOGY	232,998	19,909	38,820	291,727	90,160	68.00
69.00	06900	ELECTROCARDIOLOGY	1,056,870	76,632	197,541	1,331,043	411,368	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	454,255	52,224	74,346	580,825	179,508	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,691,331	82,489	61,505	2,835,325	876,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,119,596	0	428	4,120,024	1,273,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,606	0	658	4,264	1,318	73.00
74.00	07400	RENAL DIALYSIS	150,123	0	0	150,123	46,397	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	1,514,245	87,888	311,393	1,913,526	591,389	76.00
76.01	03480	ONCOLOGY	4,955,239	0	221,928	5,177,167	1,600,040	76.01
76.02	03330	ENDOSCOPY	387,279	0	44,805	432,084	133,539	76.02
76.03	03951	WOUND CARE	924,131	57,431	50,584	1,032,146	318,992	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,314,978	370,236	443,331	3,128,545	966,899	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	899,877	75,961	168,944	1,144,782	353,803	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	125,258,410	5,930,509	8,853,708	124,795,120	29,298,778	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,699	0	19,699	6,088	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	642,682	391,121	0	1,033,803	319,504	192.00
192.01	19201	ASC-MOB	12,799	0	0	12,799	3,956	192.01
192.02	19202	EDUCATION CENTER	12,935	0	0	12,935	3,998	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	3,446	0	3,446	1,065	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	14,861	0	0	14,861	4,593	194.01
194.02	07952	CLINIC OF HOPE	283,283	0	49,024	332,307	102,702	194.02
194.03	07953	MARKETING	821,324	0	0	821,324	253,836	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)	127,046,294	6,344,775	8,902,732	127,046,294	29,994,520	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	9,121,619					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,509	746,659				8.00
9.00	00900	HOUSEKEEPING	83,670	232,078	2,679,672			9.00
10.00	01000	DIETARY	216,129	0	0	1,232,644		10.00
11.00	01100	CAFETERIA	262,013	0	0	0	2,005,862	11.00
13.00	01300	NURSING ADMINISTRATION	109,041	0	2,050	0	37,722	13.00
15.00	01500	PHARMACY	132,833	0	31,253	0	63,567	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101,608	0	683	0	84,138	16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	37,205	0	0	0	9,289	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,222,616	241,262	845,000	852,841	426,937	30.00
31.00	03100	INTENSIVE CARE UNIT	234,026	58,984	204,985	112,665	87,322	31.00
41.00	04100	SUBPROVIDER - IRF	563,390	23,506	204,985	171,728	80,173	41.00
43.00	04300	NURSERY	66,811	9,872	101,454	95,410	18,817	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,344,199	513	453,140	0	238,254	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,532	36,363	163,838	0	69,288	52.00
53.00	05300	ANESTHESIOLOGY	11,502	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,072,177	16,719	72,428	0	96,681	54.00
54.01	03630	ULTRA SOUND	0	2,968	9,539	0	14,456	54.01
57.00	05700	CT SCAN	0	6,023	0	0	19,159	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,453	0	0	17,052	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,609	0	13,666	0	6,771	59.00
60.00	06000	LABORATORY	328,035	0	88,130	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	51,364	0	7,243	0	84,587	65.00
66.00	06600	PHYSICAL THERAPY	299,592	0	13,666	0	140,215	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,557	0	1,367	0	27,011	67.00
68.00	06800	SPEECH PATHOLOGY	43,184	0	11,780	0	5,743	68.00
69.00	06900	ELECTROCARDIOLOGY	166,218	0	5,466	0	52,455	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	113,276	0	37,745	0	22,153	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	178,924	16,206	80,545	0	54,330	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	13,666	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	190,634	0	27,331	0	79,678	76.00
76.01	03480	ONCOLOGY	0	0	0	0	53,321	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	17,053	76.02
76.03	03951	WOUND CARE	124,570	0	43,730	0	17,972	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	803,063	90,851	245,982	0	112,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	164,765	9,861	0	0	69,622	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,223,052	746,659	2,679,672	1,232,644	2,005,862	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	42,728	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	848,365	0	0	0	0	192.00
192.01	19201	ASC-MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	7,474	0	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	0	0	0	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,121,619	746,659	2,679,672	1,232,644	2,005,862	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SCHOOL OF RADIOLOGY-ALLIED HEALTH	Subtotal	
			13.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,590,979					13.00
15.00	01500	PHARMACY	0	24,016,497				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,831,271			16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	0	0	0	690,736		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	602,166	0	108,812	0	16,793,198	30.00
31.00	03100	INTENSIVE CARE UNIT	123,162	0	29,461	0	3,446,855	31.00
41.00	04100	SUBPROVIDER - IRF	113,079	0	19,209	0	3,511,276	41.00
43.00	04300	NURSERY	26,540	0	11,237	0	1,042,303	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	336,042	0	248,568	0	13,584,486	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	97,727	0	41,300	0	2,302,580	52.00
53.00	05300	ANESTHESIOLOGY	0	0	30,999	0	76,373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	85,025	355,725	5,776,053	54.00
54.01	03630	ULTRA SOUND	0	0	28,392	118,793	749,280	54.01
57.00	05700	CT SCAN	0	0	39,658	165,929	781,229	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	12,019	50,289	585,647	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,550	0	6,795	0	266,225	59.00
60.00	06000	LABORATORY	0	0	243,703	0	8,386,767	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	51,986	0	2,586,529	65.00
66.00	06600	PHYSICAL THERAPY	0	0	50,715	0	4,596,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	17,212	0	1,772,977	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,579	0	446,173	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	51,711	0	2,018,261	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	21,348	0	954,855	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	54,957	0	4,096,564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	59,616	0	5,452,962	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,995,675	189,602	0	24,190,859	73.00
74.00	07400	RENAL DIALYSIS	0	0	670	0	210,856	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	0	18,605	0	2,821,163	76.00
76.01	03480	ONCOLOGY	75,207	0	80,526	0	6,986,261	76.01
76.02	03330	ENDOSCOPY	24,053	0	20,333	0	627,062	76.02
76.03	03951	WOUND CARE	25,348	0	59,742	0	1,622,500	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	158,105	0	214,949	0	5,720,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	30,542	0	1,773,375	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,590,979	23,995,675	1,831,271	690,736	123,179,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	68,515	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,201,672	192.00
192.01	19201	ASC-MOB	0	0	0	0	16,755	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	16,933	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	11,985	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	19,454	194.01
194.02	07952	CLINIC OF HOPE	0	20,822	0	0	455,831	194.02
194.03	07953	MARKETING	0	0	0	0	1,075,160	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,590,979	24,016,497	1,831,271	690,736	127,046,294	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	16,793,198		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,446,855		31.00
41.00	04100	SUBPROVIDER - IRF	0	3,511,276		41.00
43.00	04300	NURSERY	0	1,042,303		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	13,584,486		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,302,580		52.00
53.00	05300	ANESTHESIOLOGY	0	76,373		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,776,053		54.00
54.01	03630	ULTRA SOUND	0	749,280		54.01
57.00	05700	CT SCAN	0	781,229		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	585,647		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	266,225		59.00
60.00	06000	LABORATORY	0	8,386,767		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,586,529		65.00
66.00	06600	PHYSICAL THERAPY	0	4,596,830		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,772,977		67.00
68.00	06800	SPEECH PATHOLOGY	0	446,173		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,018,261		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	954,855		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,096,564		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,452,962		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,190,859		73.00
74.00	07400	RENAL DIALYSIS	0	210,856		74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	2,821,163		76.00
76.01	03480	ONCOLOGY	0	6,986,261		76.01
76.02	03330	ENDOSCOPY	0	627,062		76.02
76.03	03951	WOUND CARE	0	1,622,500		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	5,720,490		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	1,773,375		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	123,179,989		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	68,515		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,201,672		192.00
192.01	19201	ASC-MOB	0	16,755		192.01
192.02	19202	EDUCATION CENTER	0	16,933		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	FOUNDATION	0	11,985		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	19,454		194.01
194.02	07952	CLINIC OF HOPE	0	455,831		194.02
194.03	07953	MARKETING	0	1,075,160		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	127,046,294		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	245,420	245,420	245,420		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,191,932	1,013,611	3,205,543	49,995	3,255,538	5.00
7.00	00700	OPERATION OF PLANT	0	880,410	880,410	1,719	233,737	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,916	9,916	0	18,582	8.00
9.00	00900	HOUSEKEEPING	0	38,574	38,574	0	60,574	9.00
10.00	01000	DIETARY	0	99,642	99,642	0	26,048	10.00
11.00	01100	CAFETERIA	0	120,796	120,796	0	44,685	11.00
13.00	01300	NURSING ADMINISTRATION	0	50,271	50,271	4,674	36,955	13.00
15.00	01500	PHARMACY	0	61,240	61,240	9,142	609,613	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,844	46,844	3,263	42,148	16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	0	17,153	17,153	2,184	16,508	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	563,662	563,662	40,917	320,142	30.00
31.00	03100	INTENSIVE CARE UNIT	0	107,893	107,893	8,753	66,528	31.00
41.00	04100	SUBPROVIDER - IRF	0	259,739	259,739	7,090	59,839	41.00
43.00	04300	NURSERY	0	30,802	30,802	2,184	18,249	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	619,714	619,714	24,158	280,942	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	62,484	62,484	5,922	45,062	52.00
53.00	05300	ANESTHESIOLOGY	0	5,303	5,303	0	868	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	494,305	494,305	7,625	104,479	54.00
54.01	03630	ULTRA SOUND	0	0	0	2,021	14,737	54.01
57.00	05700	CT SCAN	0	0	0	1,959	14,105	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,756	12,936	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,657	7,657	425	5,454	59.00
60.00	06000	LABORATORY	0	151,234	151,234	123	197,998	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,681	23,681	7,753	61,277	65.00
66.00	06600	PHYSICAL THERAPY	0	138,120	138,120	13,360	104,872	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	59,268	59,268	4,542	40,969	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,909	19,909	1,070	9,786	68.00
69.00	06900	ELECTROCARDIOLOGY	0	76,632	76,632	5,446	44,649	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	52,224	52,224	2,050	19,483	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	82,489	82,489	1,696	95,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12	138,202	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18	143	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	5,036	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	87,888	87,888	8,585	64,187	76.00
76.01	03480	ONCOLOGY	0	0	0	6,118	173,663	76.01
76.02	03330	ENDOSCOPY	0	0	0	1,235	14,494	76.02
76.03	03951	WOUND CARE	0	57,431	57,431	1,395	34,622	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	370,236	370,236	12,222	104,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	75,961	75,961	4,657	38,401	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,191,932	5,930,509	8,122,441	244,069	3,180,025	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,699	19,699	0	661	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	391,121	391,121	0	34,678	192.00
192.01	19201	ASC-MOB	0	0	0	0	429	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	434	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	3,446	3,446	0	116	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	498	194.01
194.02	07952	CLINIC OF HOPE	0	0	0	1,351	11,147	194.02
194.03	07953	MARKETING	0	0	0	0	27,550	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)	2,191,932	6,344,775	8,536,707	245,420	3,255,538	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,115,866					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,631	31,129				8.00
9.00	00900	HOUSEKEEPING	10,235	9,676	119,059			9.00
10.00	01000	DIETARY	26,440	0	0	152,130		10.00
11.00	01100	CAFETERIA	32,053	0	0	0	197,534	11.00
13.00	01300	NURSING ADMINISTRATION	13,339	0	91	0	3,715	13.00
15.00	01500	PHARMACY	16,250	0	1,389	0	6,260	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,430	0	30	0	8,286	16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	4,551	0	0	0	915	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	149,565	10,057	37,543	105,256	42,043	30.00
31.00	03100	INTENSIVE CARE UNIT	28,629	2,459	9,108	13,905	8,599	31.00
41.00	04100	SUBPROVIDER - IRF	68,921	980	9,108	21,194	7,895	41.00
43.00	04300	NURSERY	8,173	412	4,508	11,775	1,853	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	164,437	21	20,133	0	23,463	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,580	1,516	7,279	0	6,823	52.00
53.00	05300	ANESTHESIOLOGY	1,407	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	131,162	697	3,218	0	9,521	54.00
54.01	03630	ULTRA SOUND	0	124	424	0	1,424	54.01
57.00	05700	CT SCAN	0	251	0	0	1,887	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	61	0	0	1,679	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,032	0	607	0	667	59.00
60.00	06000	LABORATORY	40,129	0	3,916	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,284	0	322	0	8,330	65.00
66.00	06600	PHYSICAL THERAPY	36,650	0	607	0	13,808	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,727	0	61	0	2,660	67.00
68.00	06800	SPEECH PATHOLOGY	5,283	0	523	0	566	68.00
69.00	06900	ELECTROCARDIOLOGY	20,334	0	243	0	5,166	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,857	0	1,677	0	2,182	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,888	676	3,579	0	5,350	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	607	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	23,321	0	1,214	0	7,847	76.00
76.01	03480	ONCOLOGY	0	0	0	0	5,251	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	1,679	76.02
76.03	03951	WOUND CARE	15,239	0	1,943	0	1,770	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	98,240	3,788	10,929	0	11,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	20,156	411	0	0	6,856	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,005,943	31,129	119,059	152,130	197,534	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,227	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	103,782	0	0	0	0	192.00
192.01	19201	ASC-MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	914	0	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	0	0	0	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,115,866	31,129	119,059	152,130	197,534	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SCHOOL OF RADIOLOGY-ALLIED HEALTH	Subtotal	
			13.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	109,045					13.00
15.00	01500	PHARMACY	0	703,894				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	113,001			16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	0	0	0	41,311		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,273	0	6,722		1,317,180	30.00
31.00	03100	INTENSIVE CARE UNIT	8,441	0	1,820		256,135	31.00
41.00	04100	SUBPROVIDER - IRF	7,750	0	1,187		443,703	41.00
43.00	04300	NURSERY	1,819	0	694		80,469	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,032	0	15,224		1,171,124	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,698	0	2,551		154,915	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,915		9,493	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,253		756,260	54.00
54.01	03630	ULTRA SOUND	0	0	1,754		20,484	54.01
57.00	05700	CT SCAN	0	0	2,450		20,652	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	743		17,175	58.00
59.00	05900	CARDIAC CATHETERIZATION	655	0	420		17,917	59.00
60.00	06000	LABORATORY	0	0	15,056		408,456	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,212		110,859	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,133		310,550	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,063		124,290	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	221		37,358	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,195		155,665	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,319		92,792	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,395		214,181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,683		141,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	703,284	11,713		715,158	73.00
74.00	07400	RENAL DIALYSIS	0	0	41		5,684	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	0	1,149		194,191	76.00
76.01	03480	ONCOLOGY	5,155	0	4,975		195,162	76.01
76.02	03330	ENDOSCOPY	1,649	0	1,256		20,313	76.02
76.03	03951	WOUND CARE	1,737	0	3,691		117,828	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0		0	90.00
91.00	09100	EMERGENCY	10,836	0	13,279		635,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,887		148,329	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		0	98.00
99.00	09900	CMHC	0	0	0		0	99.00
99.10	09910	CORF	0	0	0		0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	109,045	703,284	113,001	0	7,893,733	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		25,587	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		529,581	192.00
192.01	19201	ASC-MOB	0	0	0		429	192.01
192.02	19202	EDUCATION CENTER	0	0	0		434	192.02
193.00	19300	NONPAID WORKERS	0	0	0		0	193.00
194.00	07950	FOUNDATION	0	0	0		4,476	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0		498	194.01
194.02	07952	CLINIC OF HOPE	0	610	0		13,108	194.02
194.03	07953	MARKETING	0	0	0		27,550	194.03
200.00		Cross Foot Adjustments				41,311	41,311	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	109,045	703,894	113,001	41,311	8,536,707	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,317,180		30.00
31.00	03100	INTENSIVE CARE UNIT	0	256,135		31.00
41.00	04100	SUBPROVIDER - IRF	0	443,703		41.00
43.00	04300	NURSERY	0	80,469		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,171,124		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	154,915		52.00
53.00	05300	ANESTHESIOLOGY	0	9,493		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	756,260		54.00
54.01	03630	ULTRA SOUND	0	20,484		54.01
57.00	05700	CT SCAN	0	20,652		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,175		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	17,917		59.00
60.00	06000	LABORATORY	0	408,456		60.00
65.00	06500	RESPIRATORY THERAPY	0	110,859		65.00
66.00	06600	PHYSICAL THERAPY	0	310,550		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	124,290		67.00
68.00	06800	SPEECH PATHOLOGY	0	37,358		68.00
69.00	06900	ELECTROCARDIOLOGY	0	155,665		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	92,792		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	214,181		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	141,897		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	715,158		73.00
74.00	07400	RENAL DIALYSIS	0	5,684		74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	194,191		76.00
76.01	03480	ONCOLOGY	0	195,162		76.01
76.02	03330	ENDOSCOPY	0	20,313		76.02
76.03	03951	WOUND CARE	0	117,828		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	635,513		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	148,329		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	7,893,733		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,587		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	529,581		192.00
192.01	19201	ASC-MOB	0	429		192.01
192.02	19202	EDUCATION CENTER	0	434		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	FOUNDATION	0	4,476		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	498		194.01
194.02	07952	CLINIC OF HOPE	0	13,108		194.02
194.03	07953	MARKETING	0	27,550		194.03
200.00		Cross Foot Adjustments	0	41,311		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	8,536,707		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	331,432					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,820	39,978,972				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,948	8,145,951	-29,994,520	97,051,774		5.00
7.00	00700	OPERATION OF PLANT	45,990	280,066	0	6,968,084	219,674	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	0	0	553,948	518	8.00
9.00	00900	HOUSEKEEPING	2,015	0	0	1,805,822	2,015	9.00
10.00	01000	DIETARY	5,205	0	0	776,525	5,205	10.00
11.00	01100	CAFETERIA	6,310	0	0	1,332,141	6,310	11.00
13.00	01300	NURSING ADMINISTRATION	2,626	761,326	0	1,101,683	2,626	13.00
15.00	01500	PHARMACY	3,199	1,489,154	0	18,172,515	3,199	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	531,540	0	1,256,509	2,447	16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	896	355,705	0	492,142	896	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	6,665,085	0	9,543,942	29,444	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	1,425,779	0	1,983,298	5,636	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	1,154,831	0	1,783,884	13,568	41.00
43.00	04300	NURSERY	1,609	355,797	0	544,027	1,609	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,372	3,935,231	0	8,375,319	32,372	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	964,582	0	1,343,358	3,264	52.00
53.00	05300	ANESTHESIOLOGY	277	0	0	25,875	277	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,821	1,242,140	0	3,114,683	25,821	54.00
54.01	03630	ULTRA SOUND	0	329,144	0	439,348	0	54.01
57.00	05700	CT SCAN	0	319,074	0	420,501	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	285,984	0	385,647	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	69,217	0	162,586	400	59.00
60.00	06000	LABORATORY	7,900	20,056	0	5,902,645	7,900	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	1,262,907	0	1,826,772	1,237	65.00
66.00	06600	PHYSICAL THERAPY	7,215	2,176,260	0	3,126,405	7,215	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	739,815	0	1,221,360	3,096	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	174,326	0	291,727	1,040	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	887,086	0	1,331,043	4,003	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	333,862	0	580,825	2,728	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	276,197	0	2,835,325	4,309	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,924	0	4,120,024	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,956	0	4,264	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	150,123	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	4,591	1,398,356	0	1,913,526	4,591	76.00
76.01	03480	ONCOLOGY	0	996,601	0	5,177,167	0	76.01
76.02	03330	ENDOSCOPY	0	201,202	0	432,084	0	76.02
76.03	03951	WOUND CARE	3,000	227,155	0	1,032,146	3,000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,340	1,990,844	0	3,128,545	19,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	758,670	0	1,144,782	3,968	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	309,792	39,758,823	-29,994,520	94,800,600	198,034	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	19,699	1,029	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	0	0	1,033,803	20,431	192.00
192.01	19201	ASC-MOB	0	0	0	12,799	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	12,935	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	180	0	0	3,446	180	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	14,861	0	194.01
194.02	07952	CLINIC OF HOPE	0	220,149	0	332,307	0	194.02
194.03	07953	MARKETING	0	0	0	821,324	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	6,344,775	8,902,732		29,994,520	9,121,619	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.143520	0.222685		0.309057	41.523435	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		245,420		3,255,538	1,115,866	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.006139		0.033544	5.079645	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	773,611					8.00
9.00	00900	HOUSEKEEPING	240,455	196,088				9.00
10.00	01000	DIETARY	0	0	25,503			10.00
11.00	01100	CAFETERIA	0	0	0	1,129,639		11.00
13.00	01300	NURSING ADMINISTRATION	0	150	0	21,244	635,256	13.00
15.00	01500	PHARMACY	0	2,287	0	35,799	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	50	0	47,384	0	16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	0	0	0	5,231	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	249,973	61,834	17,645	240,437	240,437	30.00
31.00	03100	INTENSIVE CARE UNIT	61,113	15,000	2,331	49,177	49,177	31.00
41.00	04100	SUBPROVIDER - IRF	24,355	15,000	3,553	45,151	45,151	41.00
43.00	04300	NURSERY	10,228	7,424	1,974	10,597	10,597	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	531	33,159	0	134,177	134,177	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,676	11,989	0	39,021	39,021	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,322	5,300	0	54,448	0	54.00
54.01	03630	ULTRA SOUND	3,075	698	0	8,141	0	54.01
57.00	05700	CT SCAN	6,240	0	0	10,790	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,505	0	0	9,603	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,000	0	3,813	3,813	59.00
60.00	06000	LABORATORY	0	6,449	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	530	0	47,637	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,000	0	78,965	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	100	0	15,212	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	862	0	3,234	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	400	0	29,541	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,762	0	12,476	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,791	5,894	0	30,597	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	1,000	0	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	2,000	0	44,872	0	76.00
76.01	03480	ONCOLOGY	0	0	0	30,029	30,029	76.01
76.02	03330	ENDOSCOPY	0	0	0	9,604	9,604	76.02
76.03	03951	WOUND CARE	0	3,200	0	10,121	10,121	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	94,130	18,000	0	63,129	63,129	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	10,217	0	0	39,209	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	773,611	196,088	25,503	1,129,639	635,256	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	ASC-MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	0	0	0	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	746,659	2,679,672	1,232,644	2,005,862	1,590,979	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.965161	13.665660	48.333294	1.775666	2.504469	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	31,129	119,059	152,130	197,534	109,045	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.040239	0.607171	5.965181	0.174865	0.171655	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SCHOOL OF RADIOLOGY-ALLIED HEALTH (ASSIGNED TIME)		
			15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY	4,276,876				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	491,901,371			16.00
23.00	02300	SCHOOL OF RADIOLOGY-ALLIED HEALTH	0	0	44,344,532		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	29,226,908	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,913,231	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	5,159,423	0		41.00
43.00	04300	NURSERY	0	3,018,188	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	66,786,823	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,093,247	0		52.00
53.00	05300	ANESTHESIOLOGY	0	8,326,308	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,837,752	22,837,752		54.00
54.01	03630	ULTRA SOUND	0	7,626,164	7,626,164		54.01
57.00	05700	CT SCAN	0	10,652,209	10,652,209		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,228,407	3,228,407		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,825,067	0		59.00
60.00	06000	LABORATORY	0	65,458,819	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	13,963,576	0		65.00
66.00	06600	PHYSICAL THERAPY	0	13,622,093	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,623,031	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	961,369	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,889,570	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,734,024	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,761,382	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,012,785	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,273,168	50,927,229	0		73.00
74.00	07400	RENAL DIALYSIS	0	180,030	0		74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	4,997,201	0		76.00
76.01	03480	ONCOLOGY	0	21,629,292	0		76.01
76.02	03330	ENDOSCOPY	0	5,461,446	0		76.02
76.03	03951	WOUND CARE	0	16,046,842	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	57,735,445	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	8,203,510	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,273,168	491,901,371	44,344,532		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	ASC-MOB	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	FOUNDATION	0	0	0		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0		194.01
194.02	07952	CLINIC OF HOPE	3,708	0	0		194.02
194.03	07953	MARKETING	0	0	0		194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	24,016,497	1,831,271	690,736		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.615430	0.003723	0.015577		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 2:42 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SCHOOL OF RADIOLOGY-ALLIED HEALTH (ASSIGNED TIME)			
			15.00	16.00	23.00			
204.00		Cost to be allocated (per Wkst. B, Part II)	703,894	113,001	41,311			204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.164581	0.000230	0.000932			205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 2:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,793,198		16,793,198	0	16,793,198	30.00
31.00	03100	INTENSIVE CARE UNIT	3,446,855		3,446,855	0	3,446,855	31.00
41.00	04100	SUBPROVIDER - IRF	3,511,276		3,511,276	0	3,511,276	41.00
43.00	04300	NURSERY	1,042,303		1,042,303	0	1,042,303	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,584,486		13,584,486	0	13,584,486	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,302,580		2,302,580	0	2,302,580	52.00
53.00	05300	ANESTHESIOLOGY	76,373		76,373	0	76,373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,776,053		5,776,053	0	5,776,053	54.00
54.01	03630	ULTRA SOUND	749,280		749,280	0	749,280	54.01
57.00	05700	CT SCAN	781,229		781,229	0	781,229	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	585,647		585,647	0	585,647	58.00
59.00	05900	CARDIAC CATHETERIZATION	266,225		266,225	0	266,225	59.00
60.00	06000	LABORATORY	8,386,767		8,386,767	0	8,386,767	60.00
65.00	06500	RESPIRATORY THERAPY	2,586,529	0	2,586,529	0	2,586,529	65.00
66.00	06600	PHYSICAL THERAPY	4,596,830	0	4,596,830	3,746	4,600,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,772,977	0	1,772,977	0	1,772,977	67.00
68.00	06800	SPEECH PATHOLOGY	446,173	0	446,173	0	446,173	68.00
69.00	06900	ELECTROCARDIOLOGY	2,018,261		2,018,261	0	2,018,261	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	954,855		954,855	0	954,855	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,096,564		4,096,564	0	4,096,564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,452,962		5,452,962	0	5,452,962	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,190,859		24,190,859	0	24,190,859	73.00
74.00	07400	RENAL DIALYSIS	210,856		210,856	0	210,856	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	2,821,163		2,821,163	0	2,821,163	76.00
76.01	03480	ONCOLOGY	6,986,261		6,986,261	0	6,986,261	76.01
76.02	03330	ENDOSCOPY	627,062		627,062	0	627,062	76.02
76.03	03951	WOUND CARE	1,622,500		1,622,500	0	1,622,500	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	5,720,490		5,720,490	0	5,720,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	671,547		671,547		671,547	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,773,375		1,773,375	0	1,773,375	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	123,851,536	0	123,851,536	3,746	123,855,282	200.00
201.00		Less Observation Beds	671,547		671,547		671,547	201.00
202.00		Total (see instructions)	123,179,989	0	123,179,989	3,746	123,183,735	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 2:42 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	26,237,632		26,237,632			30.00
31.00	03100	INTENSIVE CARE UNIT	7,913,231		7,913,231			31.00
41.00	04100	SUBPROVIDER - IRF	5,159,423		5,159,423			41.00
43.00	04300	NURSERY	3,018,188		3,018,188			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,315,470	42,471,353	66,786,823	0.203401	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,014,353	1,078,894	11,093,247	0.207566	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,223,435	5,102,873	8,326,308	0.009172	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,228,879	19,608,873	22,837,752	0.252917	0.000000	54.00
54.01	03630	ULTRA SOUND	1,239,238	6,386,926	7,626,164	0.098251	0.000000	54.01
57.00	05700	CT SCAN	2,203,533	8,448,676	10,652,209	0.073340	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	550,389	2,678,018	3,228,407	0.181404	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	444,914	1,380,153	1,825,067	0.145871	0.000000	59.00
60.00	06000	LABORATORY	25,511,033	39,947,786	65,458,819	0.128123	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,157,983	3,805,593	13,963,576	0.185234	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,824,303	9,797,790	13,622,093	0.337454	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,024,248	1,598,783	4,623,031	0.383510	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	564,402	396,967	961,369	0.464102	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,208,236	11,681,334	13,889,570	0.145308	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	170,668	5,563,356	5,734,024	0.166524	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,281,605	6,479,777	14,761,382	0.277519	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,573,418	3,439,367	16,012,785	0.340538	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,516,311	42,410,918	50,927,229	0.475008	0.000000	73.00
74.00	07400	RENAL DIALYSIS	173,460	6,570	180,030	1.171227	0.000000	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	51,999	4,945,202	4,997,201	0.564549	0.000000	76.00
76.01	03480	ONCOLOGY	360,635	21,268,657	21,629,292	0.323000	0.000000	76.01
76.02	03330	ENDOSCOPY	491,626	4,969,820	5,461,446	0.114816	0.000000	76.02
76.03	03951	WOUND CARE	220,301	15,826,541	16,046,842	0.101110	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	10,371,088	47,364,357	57,735,445	0.099081	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,989,276	2,989,276	0.224652	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	59,896	8,143,614	8,203,510	0.216173	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	174,109,897	317,791,474	491,901,371			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	174,109,897	317,791,474	491,901,371			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 2:42 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
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.203401	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207566	52.00
53.00	05300	ANESTHESIOLOGY	0.009172	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252917	54.00
54.01	03630	ULTRA SOUND	0.098251	54.01
57.00	05700	CT SCAN	0.073340	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.181404	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.145871	59.00
60.00	06000	LABORATORY	0.128123	60.00
65.00	06500	RESPIRATORY THERAPY	0.185234	65.00
66.00	06600	PHYSICAL THERAPY	0.337729	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383510	67.00
68.00	06800	SPEECH PATHOLOGY	0.464102	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145308	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166524	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.277519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340538	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475008	73.00
74.00	07400	RENAL DIALYSIS	1.171227	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0.564549	76.00
76.01	03480	ONCOLOGY	0.323000	76.01
76.02	03330	ENDOSCOPY	0.114816	76.02
76.03	03951	WOUND CARE	0.101110	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.099081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.224652	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.216173	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
99.00	09900	CMHC		99.00
99.10	09910	CORF		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM		100.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,793,198		16,793,198	0	16,793,198	30.00
31.00	03100	INTENSIVE CARE UNIT	3,446,855		3,446,855	0	3,446,855	31.00
41.00	04100	SUBPROVIDER - IRF	3,511,276		3,511,276	0	3,511,276	41.00
43.00	04300	NURSERY	1,042,303		1,042,303	0	1,042,303	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,584,486		13,584,486	0	13,584,486	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,302,580		2,302,580	0	2,302,580	52.00
53.00	05300	ANESTHESIOLOGY	76,373		76,373	0	76,373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,776,053		5,776,053	0	5,776,053	54.00
54.01	03630	ULTRA SOUND	749,280		749,280	0	749,280	54.01
57.00	05700	CT SCAN	781,229		781,229	0	781,229	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	585,647		585,647	0	585,647	58.00
59.00	05900	CARDIAC CATHETERIZATION	266,225		266,225	0	266,225	59.00
60.00	06000	LABORATORY	8,386,767		8,386,767	0	8,386,767	60.00
65.00	06500	RESPIRATORY THERAPY	2,586,529	0	2,586,529	0	2,586,529	65.00
66.00	06600	PHYSICAL THERAPY	4,596,830	0	4,596,830	3,746	4,600,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,772,977	0	1,772,977	0	1,772,977	67.00
68.00	06800	SPEECH PATHOLOGY	446,173	0	446,173	0	446,173	68.00
69.00	06900	ELECTROCARDIOLOGY	2,018,261		2,018,261	0	2,018,261	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	954,855		954,855	0	954,855	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,096,564		4,096,564	0	4,096,564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,452,962		5,452,962	0	5,452,962	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,190,859		24,190,859	0	24,190,859	73.00
74.00	07400	RENAL DIALYSIS	210,856		210,856	0	210,856	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	2,821,163		2,821,163	0	2,821,163	76.00
76.01	03480	ONCOLOGY	6,986,261		6,986,261	0	6,986,261	76.01
76.02	03330	ENDOSCOPY	627,062		627,062	0	627,062	76.02
76.03	03951	WOUND CARE	1,622,500		1,622,500	0	1,622,500	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	5,720,490		5,720,490	0	5,720,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	671,547		671,547		671,547	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,773,375		1,773,375	0	1,773,375	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	123,851,536	0	123,851,536	3,746	123,855,282	200.00
201.00		Less Observation Beds	671,547		671,547		671,547	201.00
202.00		Total (see instructions)	123,179,989	0	123,179,989	3,746	123,183,735	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,237,632		26,237,632			30.00
31.00	03100	INTENSIVE CARE UNIT	7,913,231		7,913,231			31.00
41.00	04100	SUBPROVIDER - IRF	5,159,423		5,159,423			41.00
43.00	04300	NURSERY	3,018,188		3,018,188			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,315,470	42,471,353	66,786,823	0.203401	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,014,353	1,078,894	11,093,247	0.207566	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,223,435	5,102,873	8,326,308	0.009172	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,228,879	19,608,873	22,837,752	0.252917	0.000000	54.00
54.01	03630	ULTRA SOUND	1,239,238	6,386,926	7,626,164	0.098251	0.000000	54.01
57.00	05700	CT SCAN	2,203,533	8,448,676	10,652,209	0.073340	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	550,389	2,678,018	3,228,407	0.181404	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	444,914	1,380,153	1,825,067	0.145871	0.000000	59.00
60.00	06000	LABORATORY	25,511,033	39,947,786	65,458,819	0.128123	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,157,983	3,805,593	13,963,576	0.185234	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,824,303	9,797,790	13,622,093	0.337454	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,024,248	1,598,783	4,623,031	0.383510	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	564,402	396,967	961,369	0.464102	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,208,236	11,681,334	13,889,570	0.145308	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	170,668	5,563,356	5,734,024	0.166524	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,281,605	6,479,777	14,761,382	0.277519	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,573,418	3,439,367	16,012,785	0.340538	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,516,311	42,410,918	50,927,229	0.475008	0.000000	73.00
74.00	07400	RENAL DIALYSIS	173,460	6,570	180,030	1.171227	0.000000	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	51,999	4,945,202	4,997,201	0.564549	0.000000	76.00
76.01	03480	ONCOLOGY	360,635	21,268,657	21,629,292	0.323000	0.000000	76.01
76.02	03330	ENDOSCOPY	491,626	4,969,820	5,461,446	0.114816	0.000000	76.02
76.03	03951	WOUND CARE	220,301	15,826,541	16,046,842	0.101110	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	10,371,088	47,364,357	57,735,445	0.099081	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,989,276	2,989,276	0.224652	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	59,896	8,143,614	8,203,510	0.216173	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	174,109,897	317,791,474	491,901,371			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	174,109,897	317,791,474	491,901,371			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
76.02	03330	ENDOSCOPY	0.000000		76.02
76.03	03951	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,584,486	1,171,124	12,413,362	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,302,580	154,915	2,147,665	0	0	52.00
53.00	05300	ANESTHESIOLOGY	76,373	9,493	66,880	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,776,053	756,260	5,019,793	0	0	54.00
54.01	03630	ULTRA SOUND	749,280	20,484	728,796	0	0	54.01
57.00	05700	CT SCAN	781,229	20,652	760,577	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	585,647	17,175	568,472	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	266,225	17,917	248,308	0	0	59.00
60.00	06000	LABORATORY	8,386,767	408,456	7,978,311	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,586,529	110,859	2,475,670	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,596,830	310,550	4,286,280	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,772,977	124,290	1,648,687	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	446,173	37,358	408,815	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,018,261	155,665	1,862,596	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	954,855	92,792	862,063	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,096,564	214,181	3,882,383	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,452,962	141,897	5,311,065	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,190,859	715,158	23,475,701	0	0	73.00
74.00	07400	RENAL DIALYSIS	210,856	5,684	205,172	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	2,821,163	194,191	2,626,972	0	0	76.00
76.01	03480	ONCOLOGY	6,986,261	195,162	6,791,099	0	0	76.01
76.02	03330	ENDOSCOPY	627,062	20,313	606,749	0	0	76.02
76.03	03951	WOUND CARE	1,622,500	117,828	1,504,672	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,720,490	635,513	5,084,977	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	671,547	52,673	618,874	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,773,375	148,329	1,625,046	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	99,057,904	5,848,919	93,208,985	0	0	200.00
201.00		Less Observation Beds	671,547	52,673	618,874	0	0	201.00
202.00		Total (line 200 minus line 201)	98,386,357	5,796,246	92,590,111	0	0	202.00

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

Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part II | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	13,584,486	66,786,823	0.203401		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,302,580	11,093,247	0.207566		52.00
53.00	05300	ANESTHESIOLOGY	76,373	8,326,308	0.009172		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,776,053	22,837,752	0.252917		54.00
54.01	03630	ULTRA SOUND	749,280	7,626,164	0.098251		54.01
57.00	05700	CT SCAN	781,229	10,652,209	0.073340		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	585,647	3,228,407	0.181404		58.00
59.00	05900	CARDIAC CATHETERIZATION	266,225	1,825,067	0.145871		59.00
60.00	06000	LABORATORY	8,386,767	65,458,819	0.128123		60.00
65.00	06500	RESPIRATORY THERAPY	2,586,529	13,963,576	0.185234		65.00
66.00	06600	PHYSICAL THERAPY	4,596,830	13,622,093	0.337454		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,772,977	4,623,031	0.383510		67.00
68.00	06800	SPEECH PATHOLOGY	446,173	961,369	0.464102		68.00
69.00	06900	ELECTROCARDIOLOGY	2,018,261	13,889,570	0.145308		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	954,855	5,734,024	0.166524		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,096,564	14,761,382	0.277519		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,452,962	16,012,785	0.340538		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,190,859	50,927,229	0.475008		73.00
74.00	07400	RENAL DIALYSIS	210,856	180,030	1.171227		74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	2,821,163	4,997,201	0.564549		76.00
76.01	03480	ONCOLOGY	6,986,261	21,629,292	0.323000		76.01
76.02	03330	ENDOSCOPY	627,062	5,461,446	0.114816		76.02
76.03	03951	WOUND CARE	1,622,500	16,046,842	0.101110		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
91.00	09100	EMERGENCY	5,720,490	57,735,445	0.099081		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	671,547	2,989,276	0.224652		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,773,375	8,203,510	0.216173		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000		98.00
99.00	09900	CMHC	0	0	0.000000		99.00
99.10	09910	CORF	0	0	0.000000		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0.000000		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	99,057,904	449,572,897			200.00
201.00		Less Observation Beds	671,547	0			201.00
202.00		Total (line 200 minus line 201)	98,386,357	449,572,897			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/22/2016 2:42 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,317,180	0	1,317,180	18,380	71.66	30.00
31.00	INTENSIVE CARE UNIT	256,135		256,135	2,331	109.88	31.00
41.00	SUBPROVIDER - IRF	443,703	0	443,703	3,553	124.88	41.00
43.00	NURSERY	80,469		80,469	1,974	40.76	43.00
200.00	Total (lines 30-199)	2,097,487		2,097,487	26,238		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	8,064	577,866	30.00
31.00	INTENSIVE CARE UNIT	1,497	164,490	31.00
41.00	SUBPROVIDER - IRF	2,780	347,166	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	12,341	1,089,522	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/22/2016 2:42 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	1,171,124	66,786,823	0.017535	12,930,005	226,728	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,915	11,093,247	0.013965	22,692	317	52.00
53.00	05300	ANESTHESIOLOGY	9,493	8,326,308	0.001140	1,681,964	1,917	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756,260	22,837,752	0.033114	1,927,010	63,811	54.00
54.01	03630	ULTRA SOUND	20,484	7,626,164	0.002686	657,480	1,766	54.01
57.00	05700	CT SCAN	20,652	10,652,209	0.001939	118,300	229	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,175	3,228,407	0.005320	277,400	1,476	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,917	1,825,067	0.009817	311,273	3,056	59.00
60.00	06000	LABORATORY	408,456	65,458,819	0.006240	12,686,111	79,161	60.00
65.00	06500	RESPIRATORY THERAPY	110,859	13,963,576	0.007939	5,598,000	44,443	65.00
66.00	06600	PHYSICAL THERAPY	310,550	13,622,093	0.022798	1,441,673	32,867	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,290	4,623,031	0.026885	1,010,129	27,157	67.00
68.00	06800	SPEECH PATHOLOGY	37,358	961,369	0.038859	266,635	10,361	68.00
69.00	06900	ELECTROCARDIOLOGY	155,665	13,889,570	0.011207	1,896,436	21,253	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	92,792	5,734,024	0.016183	95,254	1,541	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,181	14,761,382	0.014510	4,626,663	67,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	141,897	16,012,785	0.008861	7,990,744	70,806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715,158	50,927,229	0.014043	4,599,394	64,589	73.00
74.00	07400	RENAL DIALYSIS	5,684	180,030	0.031573	112,891	3,564	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	194,191	4,997,201	0.038860	0	0	76.00
76.01	03480	ONCOLOGY	195,162	21,629,292	0.009023	219,112	1,977	76.01
76.02	03330	ENDOSCOPY	20,313	5,461,446	0.003719	433,049	1,611	76.02
76.03	03951	WOUND CARE	117,828	16,046,842	0.007343	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	635,513	57,735,445	0.011007	5,555,661	61,151	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	52,673	2,989,276	0.017621	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	5,700,590	441,369,387		64,457,876	786,914	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/22/2016 2:42 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
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,380	0.00	8,064	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,331	0.00	1,497	0		31.00
41.00	04100	SUBPROVIDER - IRF	3,553	0.00	2,780	0		41.00
43.00	04300	NURSERY	1,974	0.00	0	0		43.00
200.00		Total (lines 30-199)	26,238		12,341	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/22/2016 2:42 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
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	355,725	0	355,725	54.00
54.01	03630	ULTRA SOUND	0	0	118,793	0	118,793	54.01
57.00	05700	CT SCAN	0	0	165,929	0	165,929	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	50,289	0	50,289	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		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
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	690,736	0	690,736	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/22/2016 2:42 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	66,786,823	0.000000	0.000000	12,930,005	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,093,247	0.000000	0.000000	22,692	52.00
53.00	05300	ANESTHESIOLOGY	0	8,326,308	0.000000	0.000000	1,681,964	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	355,725	22,837,752	0.015576	0.015576	1,927,010	54.00
54.01	03630	ULTRA SOUND	118,793	7,626,164	0.015577	0.015577	657,480	54.01
57.00	05700	CT SCAN	165,929	10,652,209	0.015577	0.015577	118,300	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	50,289	3,228,407	0.015577	0.015577	277,400	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,825,067	0.000000	0.000000	311,273	59.00
60.00	06000	LABORATORY	0	65,458,819	0.000000	0.000000	12,686,111	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,963,576	0.000000	0.000000	5,598,000	65.00
66.00	06600	PHYSICAL THERAPY	0	13,622,093	0.000000	0.000000	1,441,673	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,623,031	0.000000	0.000000	1,010,129	67.00
68.00	06800	SPEECH PATHOLOGY	0	961,369	0.000000	0.000000	266,635	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,889,570	0.000000	0.000000	1,896,436	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,734,024	0.000000	0.000000	95,254	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,761,382	0.000000	0.000000	4,626,663	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,012,785	0.000000	0.000000	7,990,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,927,229	0.000000	0.000000	4,599,394	73.00
74.00	07400	RENAL DIALYSIS	0	180,030	0.000000	0.000000	112,891	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	4,997,201	0.000000	0.000000	0	76.00
76.01	03480	ONCOLOGY	0	21,629,292	0.000000	0.000000	219,112	76.01
76.02	03330	ENDOSCOPY	0	5,461,446	0.000000	0.000000	433,049	76.02
76.03	03951	WOUND CARE	0	16,046,842	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	57,735,445	0.000000	0.000000	5,555,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,989,276	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	690,736	441,369,387			64,457,876	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/22/2016 2:42 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	19,514,885	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	951	0		52.00
53.00	05300	ANESTHESIOLOGY	0	1,694,036	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,015	14,263,988	222,176		54.00
54.01	03630	ULTRA SOUND	10,242	1,936,486	30,165		54.01
57.00	05700	CT SCAN	1,843	3,368,648	52,473		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,321	1,045,010	16,278		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	557,657	0		59.00
60.00	06000	LABORATORY	0	7,511,020	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,942,908	0		65.00
66.00	06600	PHYSICAL THERAPY	0	26,117	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,137	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	19,669	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,476,283	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,675,638	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,150,493	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,440,783	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,402,280	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	493,706	0		76.00
76.01	03480	ONCOLOGY	0	3,564,255	0		76.01
76.02	03330	ENDOSCOPY	0	2,477,935	0		76.02
76.03	03951	WOUND CARE	0	1,444,776	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	13,885,535	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	309,318	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Total (lines 50-199)	46,421	103,220,514	321,092		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/22/2016 2:42 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	0.203401	19,514,885	0	0	3,969,347	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207566	951	0	0	197	52.00
53.00	05300	ANESTHESIOLOGY	0.009172	1,694,036	0	0	15,538	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252917	14,263,988	0	0	3,607,605	54.00
54.01	03630	ULTRA SOUND	0.098251	1,936,486	0	0	190,262	54.01
57.00	05700	CT SCAN	0.073340	3,368,648	0	0	247,057	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.181404	1,045,010	0	0	189,569	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.145871	557,657	0	0	81,346	59.00
60.00	06000	LABORATORY	0.128123	7,511,020	850	0	962,334	60.00
65.00	06500	RESPIRATORY THERAPY	0.185234	1,942,908	0	0	359,893	65.00
66.00	06600	PHYSICAL THERAPY	0.337454	26,117	0	0	8,813	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383510	18,137	0	0	6,956	67.00
68.00	06800	SPEECH PATHOLOGY	0.464102	19,669	0	0	9,128	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145308	5,476,283	0	0	795,748	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166524	1,675,638	0	0	279,034	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.277519	2,150,493	0	0	596,803	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340538	1,440,783	0	0	490,641	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475008	18,402,280	0	16,691	8,741,230	73.00
74.00	07400	RENAL DIALYSIS	1.171227	0	0	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0.564549	493,706	0	0	278,721	76.00
76.01	03480	ONCOLOGY	0.323000	3,564,255	0	0	1,151,254	76.01
76.02	03330	ENDOSCOPY	0.114816	2,477,935	0	0	284,507	76.02
76.03	03951	WOUND CARE	0.101110	1,444,776	0	0	146,081	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.099081	13,885,535	0	0	1,375,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.224652	309,318	0	0	69,489	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.216173		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		103,220,514	850	16,691	23,857,346	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		103,220,514	850	16,691	23,857,346	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/22/2016 2:42 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
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	03630	ULTRA SOUND	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	109	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,928		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	0		76.00
76.01	03480	ONCOLOGY	0	0		76.01
76.02	03330	ENDOSCOPY	0	0		76.02
76.03	03951	WOUND CARE	0	0		76.03
		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
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	109	7,928		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	109	7,928		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II | Date/Time Prepared: 11/22/2016 2:42 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,171,124	66,786,823	0.017535	12,350	217	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,915	11,093,247	0.013965	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,493	8,326,308	0.001140	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756,260	22,837,752	0.033114	86,258	2,856	54.00
54.01	03630	ULTRA SOUND	20,484	7,626,164	0.002686	24,800	67	54.01
57.00	05700	CT SCAN	20,652	10,652,209	0.001939	29,750	58	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,175	3,228,407	0.005320	3,800	20	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,917	1,825,067	0.009817	0	0	59.00
60.00	06000	LABORATORY	408,456	65,458,819	0.006240	1,060,904	6,620	60.00
65.00	06500	RESPIRATORY THERAPY	110,859	13,963,576	0.007939	609,715	4,841	65.00
66.00	06600	PHYSICAL THERAPY	310,550	13,622,093	0.022798	1,297,641	29,584	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,290	4,623,031	0.026885	1,223,410	32,891	67.00
68.00	06800	SPEECH PATHOLOGY	37,358	961,369	0.038859	148,985	5,789	68.00
69.00	06900	ELECTROCARDIOLOGY	155,665	13,889,570	0.011207	15,438	173	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	92,792	5,734,024	0.016183	3,928	64	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,181	14,761,382	0.014510	279,298	4,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	141,897	16,012,785	0.008861	5,297	47	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715,158	50,927,229	0.014043	514,073	7,219	73.00
74.00	07400	RENAL DIALYSIS	5,684	180,030	0.031573	30,898	976	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	194,191	4,997,201	0.038860	0	0	76.00
76.01	03480	ONCOLOGY	195,162	21,629,292	0.009023	0	0	76.01
76.02	03330	ENDOSCOPY	20,313	5,461,446	0.003719	0	0	76.02
76.03	03951	WOUND CARE	117,828	16,046,842	0.007343	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	635,513	57,735,445	0.011007	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,989,276	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	5,647,917	441,369,387		5,346,545	95,475	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/22/2016 2:42 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	355,725	0	355,725	54.00
54.01	03630	ULTRA SOUND	0	0	118,793	0	118,793	54.01
57.00	05700	CT SCAN	0	0	165,929	0	165,929	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	50,289	0	50,289	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		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
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	690,736	0	690,736	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/22/2016 2:42 pm

Title XVIII | Subprovider - IRF | 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	66,786,823	0.000000	0.000000	12,350	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,093,247	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	8,326,308	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	355,725	22,837,752	0.015576	0.015576	86,258	54.00
54.01	03630	ULTRA SOUND	118,793	7,626,164	0.015577	0.015577	24,800	54.01
57.00	05700	CT SCAN	165,929	10,652,209	0.015577	0.015577	29,750	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	50,289	3,228,407	0.015577	0.015577	3,800	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,825,067	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	65,458,819	0.000000	0.000000	1,060,904	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,963,576	0.000000	0.000000	609,715	65.00
66.00	06600	PHYSICAL THERAPY	0	13,622,093	0.000000	0.000000	1,297,641	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,623,031	0.000000	0.000000	1,223,410	67.00
68.00	06800	SPEECH PATHOLOGY	0	961,369	0.000000	0.000000	148,985	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,889,570	0.000000	0.000000	15,438	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,734,024	0.000000	0.000000	3,928	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,761,382	0.000000	0.000000	279,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,012,785	0.000000	0.000000	5,297	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,927,229	0.000000	0.000000	514,073	73.00
74.00	07400	RENAL DIALYSIS	0	180,030	0.000000	0.000000	30,898	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	4,997,201	0.000000	0.000000	0	76.00
76.01	03480	ONCOLOGY	0	21,629,292	0.000000	0.000000	0	76.01
76.02	03330	ENDOSCOPY	0	5,461,446	0.000000	0.000000	0	76.02
76.03	03951	WOUND CARE	0	16,046,842	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	57,735,445	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,989,276	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	690,736	441,369,387			5,346,545	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/22/2016 2:42 pm

Title XVIII | Subprovider - IRF | 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
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	1,344	0	0		54.00
54.01	03630	ULTRA SOUND	386	0	0		54.01
57.00	05700	CT SCAN	463	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	59	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	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	BEHAVIORAL HEALTH SERVICES	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0		76.01
76.02	03330	ENDOSCOPY	0	0	0		76.02
76.03	03951	WOUND CARE	0	0	0		76.03
		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
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Total (lines 50-199)	2,252	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,317,180	0	1,317,180	18,380	71.66	30.00
31.00	INTENSIVE CARE UNIT	256,135		256,135	2,331	109.88	31.00
41.00	SUBPROVIDER - IRF	443,703	0	443,703	3,553	124.88	41.00
43.00	NURSERY	80,469		80,469	1,974	40.76	43.00
200.00	Total (lines 30-199)	2,097,487		2,097,487	26,238		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	416	29,811				30.00
31.00	INTENSIVE CARE UNIT	196	21,536				31.00
41.00	SUBPROVIDER - IRF	55	6,868				41.00
43.00	NURSERY	280	11,413				43.00
200.00	Total (lines 30-199)	947	69,628				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,171,124	66,786,823	0.017535	2,480,670	43,499	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,915	11,093,247	0.013965	5,796,968	80,955	52.00
53.00	05300	ANESTHESIOLOGY	9,493	8,326,308	0.001140	275,452	314	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756,260	22,837,752	0.033114	232,428	7,697	54.00
54.01	03630	ULTRA SOUND	20,484	7,626,164	0.002686	114,642	308	54.01
57.00	05700	CT SCAN	20,652	10,652,209	0.001939	199,616	387	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,175	3,228,407	0.005320	60,216	320	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,917	1,825,067	0.009817	13,415	132	59.00
60.00	06000	LABORATORY	408,456	65,458,819	0.006240	3,888,879	24,267	60.00
65.00	06500	RESPIRATORY THERAPY	110,859	13,963,576	0.007939	772,813	6,135	65.00
66.00	06600	PHYSICAL THERAPY	310,550	13,622,093	0.022798	183,866	4,192	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,290	4,623,031	0.026885	88,598	2,382	67.00
68.00	06800	SPEECH PATHOLOGY	37,358	961,369	0.038859	14,683	571	68.00
69.00	06900	ELECTROCARDIOLOGY	155,665	13,889,570	0.011207	150,566	1,687	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	92,792	5,734,024	0.016183	19,640	318	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,181	14,761,382	0.014510	849,381	12,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	141,897	16,012,785	0.008861	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715,158	50,927,229	0.014043	992,055	13,931	73.00
74.00	07400	RENAL DIALYSIS	5,684	180,030	0.031573	1,215	38	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	194,191	4,997,201	0.038860	14,647	569	76.00
76.01	03480	ONCOLOGY	195,162	21,629,292	0.009023	37,733	340	76.01
76.02	03330	ENDOSCOPY	20,313	5,461,446	0.003719	38,684	144	76.02
76.03	03951	WOUND CARE	117,828	16,046,842	0.007343	29,090	214	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	635,513	57,735,445	0.011007	1,349,473	14,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	52,673	2,989,276	0.017621	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	5,700,590	441,369,387		17,604,730	215,579	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,380	0.00	416	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,331	0.00	196	0		31.00
41.00	04100	SUBPROVIDER - IRF	3,553	0.00	55	0		41.00
43.00	04300	NURSERY	1,974	0.00	280	0		43.00
200.00		Total (lines 30-199)	26,238		947	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	355,725	0	355,725	54.00
54.01	03630	ULTRA SOUND	0	0	118,793	0	118,793	54.01
57.00	05700	CT SCAN	0	0	165,929	0	165,929	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	50,289	0	50,289	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		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
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	690,736	0	690,736	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	66,786,823	0.000000	0.000000	2,480,670	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,093,247	0.000000	0.000000	5,796,968	52.00
53.00	05300	ANESTHESIOLOGY	0	8,326,308	0.000000	0.000000	275,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	355,725	22,837,752	0.015576	0.015576	232,428	54.00
54.01	03630	ULTRA SOUND	118,793	7,626,164	0.015577	0.015577	114,642	54.01
57.00	05700	CT SCAN	165,929	10,652,209	0.015577	0.015577	199,616	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	50,289	3,228,407	0.015577	0.015577	60,216	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,825,067	0.000000	0.000000	13,415	59.00
60.00	06000	LABORATORY	0	65,458,819	0.000000	0.000000	3,888,879	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,963,576	0.000000	0.000000	772,813	65.00
66.00	06600	PHYSICAL THERAPY	0	13,622,093	0.000000	0.000000	183,866	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,623,031	0.000000	0.000000	88,598	67.00
68.00	06800	SPEECH PATHOLOGY	0	961,369	0.000000	0.000000	14,683	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,889,570	0.000000	0.000000	150,566	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,734,024	0.000000	0.000000	19,640	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,761,382	0.000000	0.000000	849,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,012,785	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,927,229	0.000000	0.000000	992,055	73.00
74.00	07400	RENAL DIALYSIS	0	180,030	0.000000	0.000000	1,215	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	4,997,201	0.000000	0.000000	14,647	76.00
76.01	03480	ONCOLOGY	0	21,629,292	0.000000	0.000000	37,733	76.01
76.02	03330	ENDOSCOPY	0	5,461,446	0.000000	0.000000	38,684	76.02
76.03	03951	WOUND CARE	0	16,046,842	0.000000	0.000000	29,090	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	57,735,445	0.000000	0.000000	1,349,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,989,276	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	690,736	441,369,387			17,604,730	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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	3,620	0	0		54.00
54.01	03630	ULTRA SOUND	1,786	0	0		54.01
57.00	05700	CT SCAN	3,109	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	938	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	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	BEHAVIORAL HEALTH SERVICES	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0		76.01
76.02	03330	ENDOSCOPY	0	0	0		76.02
76.03	03951	WOUND CARE	0	0	0		76.03
		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
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Total (lines 50-199)	9,453	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.203401	0	2,091,006	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207566	0	91,882	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.009172	0	279,886	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252917	0	1,434,517	0	0	54.00
54.01	03630	ULTRA SOUND	0.098251	0	459,218	0	0	54.01
57.00	05700	CT SCAN	0.073340	0	882,936	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.181404	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.145871	0	61,238	0	0	59.00
60.00	06000	LABORATORY	0.128123	0	5,172,810	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.185234	0	419,212	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.337454	0	373,058	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383510	0	141,183	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.464102	0	23,908	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145308	0	475,658	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166524	0	424,162	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.277519	0	616,439	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340538	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475008	0	371,503	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.171227	0	0	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0.564549	0	1,587,265	0	0	76.00
76.01	03480	ONCOLOGY	0.323000	0	2,896,059	0	0	76.01
76.02	03330	ENDOSCOPY	0.114816	0	165,842	0	0	76.02
76.03	03951	WOUND CARE	0.101110	0	875,330	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.099081	0	7,594,516	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.224652	0	1,516,587	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.216173	0	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	27,954,215	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	27,954,215	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	425,313	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,072	0		52.00
53.00	05300	ANESTHESIOLOGY	2,567	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	362,814	0		54.00
54.01	03630	ULTRA SOUND	45,119	0		54.01
57.00	05700	CT SCAN	64,755	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	8,933	0		59.00
60.00	06000	LABORATORY	662,756	0		60.00
65.00	06500	RESPIRATORY THERAPY	77,652	0		65.00
66.00	06600	PHYSICAL THERAPY	125,890	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	54,145	0		67.00
68.00	06800	SPEECH PATHOLOGY	11,096	0		68.00
69.00	06900	ELECTROCARDIOLOGY	69,117	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70,633	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	171,074	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,467	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	896,089	0		76.00
76.01	03480	ONCOLOGY	935,427	0		76.01
76.02	03330	ENDOSCOPY	19,041	0		76.02
76.03	03951	WOUND CARE	88,505	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	752,472	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	340,704	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	5,379,641	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,379,641	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.203401	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207566	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.009172	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252917	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.098251	0	0	0	0	54.01
57.00	05700	CT SCAN	0.073340	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.181404	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.145871	0	0	0	0	59.00
60.00	06000	LABORATORY	0.128123	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.185234	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.337454	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383510	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.464102	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145308	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166524	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.277519	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340538	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475008	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.171227	0	0	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0.564549	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.323000	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.114816	0	0	0	0	76.02
76.03	03951	WOUND CARE	0.101110	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.099081	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.224652	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.216173		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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	03630	ULTRA SOUND	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0	0		76.00
76.01	03480	ONCOLOGY	0	0		76.01
76.02	03330	ENDOSCOPY	0	0		76.02
76.03	03951	WOUND CARE	0	0		76.03
		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
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 2:42 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)	18,380	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,380	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)	17,645	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)	8,064	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)	16,793,198	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)	16,793,198	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)	16,793,198	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)	913.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,367,835	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)	7,367,835	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 2:42 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	3,446,855	2,331	1,478.70	1,497	2,213,614	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	14,251,339	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	23,832,788	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)	742,356	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	833,335	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,575,691	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	22,257,097	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)	735	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	913.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	671,547	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 2:42 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	1,317,180	16,793,198	0.078435	671,547	52,673	90.00
91.00	Nursing School cost	0	16,793,198	0.000000	671,547	0	91.00
92.00	Allied health cost	0	16,793,198	0.000000	671,547	0	92.00
93.00	All other Medical Education	0	16,793,198	0.000000	671,547	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/22/2016 2:42 pm
	Title XVIII	Subprovider - IRF	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)	3,553	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,553	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)	3,553	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)	2,780	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)	3,511,276	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)	3,511,276	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,511,276	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)	988.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,747,363	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)	2,747,363	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 2:42 pm

Title XVIII | Subprovider - IRF | 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,617,677	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,365,040	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	347,166	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	97,727	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	444,893	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,920,147	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 2:42 pm

Title XVIII | Subprovider - IRF | 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	443,703	3,511,276	0.126365	0	0	90.00
91.00	Nursing School cost	0	3,511,276	0.000000	0	0	91.00
92.00	Allied health cost	0	3,511,276	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,511,276	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	18,380	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,380	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)	17,645	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)	416	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)	1,974	15.00
16.00	Nursery days (title V or XIX only)	280	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)	16,793,198	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)	16,793,198	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)	16,793,198	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)	913.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	380,087	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)	380,087	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,042,303	1,974	528.02	280	147,846	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,446,855	2,331	1,478.70	196	289,825	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,447,235	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,264,993	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	735	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	913.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	671,547	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,317,180	16,793,198	0.078435	671,547	52,673	90.00
91.00	Nursing School cost	0	16,793,198	0.000000	671,547	0	91.00
92.00	Allied health cost	0	16,793,198	0.000000	671,547	0	92.00
93.00	All other Medical Education	0	16,793,198	0.000000	671,547	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/22/2016 2:42 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,553	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,553	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)	3,553	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	3,553	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)	55	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)	1,974	15.00
16.00	Nursery days (title V or XIX only)	280	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)	3,511,276	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)	3,511,276	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,511,276	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)	988.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	54,354	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)	54,354	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1

Component CCN: 15T010 | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	67,115	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	121,469	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1

Component CCN: 15T010 | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	443,703	3,511,276	0.126365	0	0	90.00
91.00	Nursing School cost	0	3,511,276	0.000000	0	0	91.00
92.00	Allied health cost	0	3,511,276	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,511,276	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/22/2016 2:42 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		12,039,909		30.00
31.00	03100	INTENSIVE CARE UNIT		5,095,254		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.203401	12,930,005	2,629,976	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207566	22,692	4,710	52.00
53.00	05300	ANESTHESIOLOGY	0.009172	1,681,964	15,427	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252917	1,927,010	487,374	54.00
54.01	03630	ULTRA SOUND	0.098251	657,480	64,598	54.01
57.00	05700	CT SCAN	0.073340	118,300	8,676	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.181404	277,400	50,321	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.145871	311,273	45,406	59.00
60.00	06000	LABORATORY	0.128123	12,686,111	1,625,383	60.00
65.00	06500	RESPIRATORY THERAPY	0.185234	5,598,000	1,036,940	65.00
66.00	06600	PHYSICAL THERAPY	0.337729	1,441,673	486,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383510	1,010,129	387,395	67.00
68.00	06800	SPEECH PATHOLOGY	0.464102	266,635	123,746	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145308	1,896,436	275,567	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166524	95,254	15,862	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.277519	4,626,663	1,283,987	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340538	7,990,744	2,721,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475008	4,599,394	2,184,749	73.00
74.00	07400	RENAL DIALYSIS	1.171227	112,891	132,221	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0.564549	0	0	76.00
76.01	03480	ONCOLOGY	0.323000	219,112	70,773	76.01
76.02	03330	ENDOSCOPY	0.114816	433,049	49,721	76.02
76.03	03951	WOUND CARE	0.101110	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.099081	5,555,661	550,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.224652	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		64,457,876	14,251,339	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)		64,457,876		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/22/2016 2:42 pm

Title XVIII | Subprovider - IRF | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		4,060,340		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.203401	12,350	2,512	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207566	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.009172	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252917	86,258	21,816	54.00
54.01	03630	ULTRA SOUND	0.098251	24,800	2,437	54.01
57.00	05700	CT SCAN	0.073340	29,750	2,182	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.181404	3,800	689	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.145871	0	0	59.00
60.00	06000	LABORATORY	0.128123	1,060,904	135,926	60.00
65.00	06500	RESPIRATORY THERAPY	0.185234	609,715	112,940	65.00
66.00	06600	PHYSICAL THERAPY	0.337729	1,297,641	438,251	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383510	1,223,410	469,190	67.00
68.00	06800	SPEECH PATHOLOGY	0.464102	148,985	69,144	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145308	15,438	2,243	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166524	3,928	654	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.277519	279,298	77,511	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340538	5,297	1,804	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475008	514,073	244,189	73.00
74.00	07400	RENAL DIALYSIS	1.171227	30,898	36,189	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0.564549	0	0	76.00
76.01	03480	ONCOLOGY	0.323000	0	0	76.01
76.02	03330	ENDOSCOPY	0.114816	0	0	76.02
76.03	03951	WOUND CARE	0.101110	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.099081	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.224652	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		5,346,545	1,617,677	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)		5,346,545		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,393,643		30.00
31.00	03100	INTENSIVE CARE UNIT		732,666		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		1,544,706		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.203401	2,480,670	504,571	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207566	5,796,968	1,203,253	52.00
53.00	05300	ANESTHESIOLOGY	0.009172	275,452	2,526	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252917	232,428	58,785	54.00
54.01	03630	ULTRA SOUND	0.098251	114,642	11,264	54.01
57.00	05700	CT SCAN	0.073340	199,616	14,640	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.181404	60,216	10,923	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.145871	13,415	1,957	59.00
60.00	06000	LABORATORY	0.128123	3,888,879	498,255	60.00
65.00	06500	RESPIRATORY THERAPY	0.185234	772,813	143,151	65.00
66.00	06600	PHYSICAL THERAPY	0.337454	183,866	62,046	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383510	88,598	33,978	67.00
68.00	06800	SPEECH PATHOLOGY	0.464102	14,683	6,814	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145308	150,566	21,878	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166524	19,640	3,271	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.277519	849,381	235,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340538	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475008	992,055	471,234	73.00
74.00	07400	RENAL DIALYSIS	1.171227	1,215	1,423	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0.564549	14,647	8,269	76.00
76.01	03480	ONCOLOGY	0.323000	37,733	12,188	76.01
76.02	03330	ENDOSCOPY	0.114816	38,684	4,442	76.02
76.03	03951	WOUND CARE	0.101110	29,090	2,941	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.099081	1,349,473	133,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.224652	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		17,604,730	3,447,235	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)		17,604,730		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/22/2016 2:42 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		183,491		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.203401	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.207566	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.009172	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252917	4,270	1,080	54.00
54.01	03630	ULTRA SOUND	0.098251	0	0	54.01
57.00	05700	CT SCAN	0.073340	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.181404	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.145871	0	0	59.00
60.00	06000	LABORATORY	0.128123	44,771	5,736	60.00
65.00	06500	RESPIRATORY THERAPY	0.185234	17,308	3,206	65.00
66.00	06600	PHYSICAL THERAPY	0.337454	92,264	31,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383510	34,270	13,143	67.00
68.00	06800	SPEECH PATHOLOGY	0.464102	5,272	2,447	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145308	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166524	982	164	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.277519	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340538	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475008	20,697	9,831	73.00
74.00	07400	RENAL DIALYSIS	1.171227	0	0	74.00
76.00	03950	BEHAVIORAL HEALTH SERVICES	0.564549	660	373	76.00
76.01	03480	ONCOLOGY	0.323000	0	0	76.01
76.02	03330	ENDOSCOPY	0.114816	0	0	76.02
76.03	03951	WOUND CARE	0.101110	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.099081	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.224652	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		220,494	67,115	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)		220,494		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150010	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/22/2016 2:42 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)	4,024,163	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	12,898,292	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)	565,522	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	2,528,612	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	104.99	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)	3.85	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.86	31.00
32.00	Sum of lines 30 and 31	27.71	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.08	33.00
34.00	Disproportionate share adjustment (see instructions)	511,059	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150010	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/22/2016 2:42 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,250,131	1,026,564	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	315,102	768,521	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,083,623		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)	2,063		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)	19,082,659		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)	19,082,659	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,461,167	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	13,500	53.00
54.00	Special add-on payments for new technologies	0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	46,421	58.00
59.00	Total (sum of amounts on lines 49 through 58)	20,603,747	59.00
60.00	Primary payer payments	5,145	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	20,598,602	61.00
62.00	Deductibles billed to program beneficiaries	1,934,856	62.00
63.00	Coinsurance billed to program beneficiaries	61,103	63.00
64.00	Allowable bad debts (see instructions)	178,738	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	116,180	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	49,618	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,718,823	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	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)	43,973	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150010	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/22/2016 2:42 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,762,796	71.00
71.01	Sequestration adjustment (see instructions)		375,256	71.01
72.00	Interim payments		18,299,487	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)		88,053	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		158,323	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150010	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/22/2016 2:42 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,037	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	23,536,254	2.00
3.00	PPS payments	19,057,403	3.00
4.00	Outlier payment (see instructions)	87,676	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.250	5.00
6.00	Line 2 times line 5	5,884,064	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	321,092	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	8,037	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	17,541	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)	17,541	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)	17,541	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	9,504	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)	8,037	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)	19,466,171	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	836	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,865,575	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)	15,607,797	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)	15,607,797	30.00
31.00	Primary payer payments	5,296	31.00
32.00	Subtotal (line 30 minus line 31)	15,602,501	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)	337,918	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	219,647	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	167,343	36.00
37.00	Subtotal (see instructions)	15,822,148	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	15,822,148	40.00
40.01	Sequestration adjustment (see instructions)	316,443	40.01
41.00	Interim payments	15,389,791	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	115,914	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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 11/22/2016 2:42 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		18,256,587		15,298,391	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	01/20/2016	42,900	01/20/2016	91,400	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)		42,900		91,400	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)		18,299,487		15,389,791	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		88,053		115,914	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		18,387,540		15,505,705	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150010 | Component CCN: 15T010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2016 2:42 pm

Title XVIII | Subprovider - IRF | 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		4,070,250		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		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)		4,070,250		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		12,512		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,082,762		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150010	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/22/2016 2:42 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	6,006	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	9,561	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,592	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	19,976	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	491,901,371	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	10,787,942	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)	848,038	8.00
9.00	Sequestration adjustment amount (see instructions)	16,961	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	831,077	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	805,428	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)	25,649	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part III Date/Time Prepared: 11/22/2016 2:42 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,084,803	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0263	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	108,656	3.00
4.00	Outlier Payments	60,247	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	9.707650	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4,253,706	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,253,706	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,253,706	19.00
20.00	Deductibles	80,276	20.00
21.00	Subtotal (line 19 minus line 20)	4,173,430	21.00
22.00	Coinsurance	16,289	22.00
23.00	Subtotal (line 21 minus line 22)	4,157,141	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,294	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	6,691	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,672	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,163,832	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	2,252	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,166,084	32.00
32.01	Sequestration adjustment (see instructions)	83,322	32.01
33.00	Interim payments	4,070,250	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	12,512	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	36,763	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	60,247	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150010	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2016 2:42 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	4,264,993		1.00
2.00	Medical and other services		5,379,641	2.00
3.00	Organ acquisition (certified transplant centers only)	5,671,015		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	9,936,008	5,379,641	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)	9,936,008	5,379,641	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	5,671,015		8.00
9.00	Ancillary service charges	17,604,730	27,954,215	9.00
10.00	Organ acquisition charges, net of revenue	5,671,015		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	28,946,760	27,954,215	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)	28,946,760	27,954,215	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	19,010,752	22,574,574	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)	9,936,008	5,379,641	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)	9,936,008	5,379,641	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)	9,936,008	5,379,641	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)	9,936,008	5,379,641	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	9,936,008	5,379,641	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)	9,936,008	5,379,641	40.00
41.00	Interim payments	9,936,008	5,379,641	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2016 2:42 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	121,469		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	121,469	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	121,469	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	220,494	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	220,494	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	220,494	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	99,025	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	121,469	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	121,469	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	121,469	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	121,469	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	121,469	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)	121,469	0	40.00
41.00	Interim payments	121,469	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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/22/2016 2:42 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	1,520	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	46,130,173	0	0	0	4.00
5.00	Other receivable	999,404	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-26,822,788	0	0	0	6.00
7.00	Inventory	1,858,816	0	0	0	7.00
8.00	Prepaid expenses	130,047	0	0	0	8.00
9.00	Other current assets	1,004,437	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)	23,301,609	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	722,779	0	0	0	12.00
13.00	Land improvements	1,764,978	0	0	0	13.00
14.00	Accumulated depreciation	-1,373,654	0	0	0	14.00
15.00	Buildings	87,352,168	0	0	0	15.00
16.00	Accumulated depreciation	-49,282,721	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	37,992,015	0	0	0	23.00
24.00	Accumulated depreciation	-52,594,989	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	590,153	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,170,729	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	144,512,883	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	83,561	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	144,596,444	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	193,068,782	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,960,743	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,943,548	0	0	0	38.00
39.00	Payroll taxes payable	318,759	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,279,393	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,880,625	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,383,068	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	211,310	0	0	0	46.00
47.00	Notes payable	15,907,534	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,937,907	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,056,751	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	34,439,819	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	158,628,963				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)	158,628,963	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	193,068,782	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/22/2016 2:42 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		168,332,651		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		25,355,717				2.00
3.00	Total (sum of line 1 and line 2)		193,688,368		0		3.00
4.00	RELEASE OF RESTRICED ASSETS	160,968		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)		160,968		0		10.00
11.00	Subtotal (line 3 plus line 10)		193,849,336		0		11.00
12.00	RECONCILING ITEM	395,437		0		0	12.00
13.00	TRANSFER TO AFFILIATES	34,702,616		0		0	13.00
14.00	UNRESTRICTED CONTROLLING INTEREST	122,320		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)		35,220,373		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		158,628,963		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	RELEASE OF RESTRICED ASSETS		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	RECONCILING ITEM		0			12.00
13.00	TRANSFER TO AFFILIATES		0			13.00
14.00	UNRESTRICTED CONTROLLING INTEREST		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: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/22/2016 2:42 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	29,508,625		29,508,625	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,191,409		5,191,409	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)	34,700,034		34,700,034	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	8,032,420		8,032,420	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	8,032,420		8,032,420	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,732,454		42,732,454	17.00
18.00	Ancillary services	131,375,668	307,059,298	438,434,966	18.00
19.00	Outpatient services	0	10,732,177	10,732,177	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN	0	88,854	88,854	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	174,108,122	317,880,329	491,988,451	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		126,245,793		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)		126,245,793		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150010 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-3 | Date/Time Prepared: 11/22/2016 2:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	491,988,451	1.00
2.00	Less contractual allowances and discounts on patients' accounts	338,559,203	2.00
3.00	Net patient revenues (line 1 minus line 2)	153,429,248	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	126,245,793	4.00
5.00	Net income from service to patients (line 3 minus line 4)	27,183,455	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	22,351	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	642,802	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	21,765	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	457,092	22.00
23.00	Governmental appropriations	957,007	23.00
24.00	OTHER MISCELLANEOUS REVENUE	291,793	24.00
25.00	Total other income (sum of lines 6-24)	2,392,810	25.00
26.00	Total (line 5 plus line 25)	29,576,265	26.00
27.00	LOSS ON INVESTMENTS	4,220,548	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4,220,548	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	25,355,717	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150010	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/22/2016 2:42 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,345,563	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	37,965	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)	55.80	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)	3.85	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	23.86	8.00
9.00	Sum of lines 7 and 8	27.71	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.77	10.00
11.00	Disproportionate share adjustment (see instructions)	77,639	11.00
12.00	Total prospective capital payments (see instructions)	1,461,167	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