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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/23/2016 10:59 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/23/2016 Time: 10:59 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT CARMEL HOSPITAL (150157) for the cost reporting period beginning 07/01/2015 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	131,647	78,255	33,254	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	131,647	78,255	33,254	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2016 10:54 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13500 NORTH MERIDIAN STREET	PO Box:			1.00
2.00	City: CARMEL	State: IN	Zip Code: 46033	County: HAMILTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT CARMEL HOSPITAL	150157	26900	1	01/14/2004	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 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)	N	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.	186	28	3	3	2,229	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2016 10:54 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2016 10:54 am

		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: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/23/2016 10:54 am

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	697,897	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: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2016 10:54 am

		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	269008	140.00

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/23/2016 10:54 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	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: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/23/2016 10:54 am

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

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

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

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

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

		Part A		Part B		
		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: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/23/2016 10:54 am

		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.	JOHN	KUHN	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3236	JOHN.KUHN@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/23/2016 10:54 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/23/2016 10:54 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	128	46,848	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		128	46,848	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,660	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	15	5,490	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		153	55,998	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		153				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/23/2016 10:54 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,437	95	13,124			1.00
2.00	HMO and other (see instructions)	1,181	2,229				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,437	95	13,124			7.00
8.00	INTENSIVE CARE UNIT	386	46	922			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	0	0	1,812			12.00
13.00	NURSERY		79	3,334			13.00
14.00	Total (see instructions)	4,823	220	19,192	0.00	615.31	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	615.31	27.00
28.00	Observation Bed Days		0	1,772			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			918			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	890			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/23/2016 10:54 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,284	75	6,544	1.00
2.00	HMO and other (see instructions)			312	593		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,284	75	6,544	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 11/23/2016 10:54 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	46,141,899	0	46,141,899	1,280,149.58	36.04	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		538,277	0	538,277	2,405.92	223.73	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		3,189,108	0	3,189,108	23,791.32	134.05	5.00
6.00	Non-physician-Part B		195,587	0	195,587	4,160.00	47.02	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		2,236,226	0	2,236,226	105,605.34	21.18	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,568,233	0	5,568,233	148,349.68	37.53	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		54,874	0	54,874	1,066.44	51.46	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		1,606,514	0	1,606,514	17,355.16	92.57	13.00
14.00	Home office salaries & wage-related costs		13,195,223	0	13,195,223	268,365.00	49.17	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,589,113	0	10,589,113			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,608,686	0	1,608,686			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		154,933	0	154,933			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		921,346	0	921,346			23.00
24.00	Wage-related costs (RHC/FQHC)		56,506	0	56,506			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	543,956	0	543,956	13,942.04	39.02	26.00
27.00	Administrative & General	5.00	6,159,927	0	6,159,927	151,226.08	40.73	27.00
28.00	Administrative & General under contract (see inst.)		427,653	0	427,653	1,498.04	285.48	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	193,398	0	193,398	10,168.06	19.02	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)		1,441,189	0	1,441,189	66,790.19	21.58	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		599,541	0	599,541	15,970.68	37.54	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,446,624	0	1,446,624	32,204.12	44.92	38.00
39.00	Central Services and Supply	14.00	332,527	0	332,527	16,323.15	20.37	39.00
40.00	Pharmacy	15.00	2,125,375	0	2,125,375	51,684.35	41.12	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 11/23/2016 10:54 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	254,854	0	254,854	14,552.61	17.51	41.00
42.00	Social Service	17.00	163,391	0	163,391	4,732.42	34.53	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 11/23/2016 10:54 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		42,989,361	0	42,989,361	1,230,851.83	34.93	1.00
2.00	Excluded area salaries (see instructions)		5,568,233	0	5,568,233	148,349.68	37.53	2.00
3.00	Subtotal salaries (line 1 minus line 2)		37,421,128	0	37,421,128	1,082,502.15	34.57	3.00
4.00	Subtotal other wages & related costs (see inst.)		14,856,611	0	14,856,611	286,786.60	51.80	4.00
5.00	Subtotal wage-related costs (see inst.)		10,744,046	0	10,744,046	0.00	28.71	5.00
6.00	Total (sum of lines 3 thru 5)		63,021,785	0	63,021,785	1,369,288.75	46.03	6.00
7.00	Total overhead cost (see instructions)		13,688,435	0	13,688,435	379,091.74	36.11	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 11/23/2016 10:54 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,035,589	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)	348,469	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)	5,314,077	8.00
9.00	Prescription Drug Plan	1,105,920	9.00
10.00	Dental, Hearing and Vision Plan	92,421	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	57,934	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	1,718	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	339,176	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	38,186	14.00
15.00	'Workers' Compensation Insurance	575,392	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	36	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,289,345	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	26,446	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	68,238	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	37,636	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,330,583	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part V | Date/Time Prepared: 11/23/2016 10:54 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,401	13,330,583	1.00
2.00	Hospital	4,401	10,589,113	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	2,741,470	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/23/2016 10:54 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.217800	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,908,990	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	49,579,028	6.00
7.00	Medicaid cost (line 1 times line 6)	10,798,312	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)	7,889,322	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)	7,889,322	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	4,201,622	2,773,974	6,975,596	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	915,113	604,172	1,519,285	21.00
22.00	Partial payment by patients approved for charity care	276,604	276,604	553,208	22.00
23.00	Cost of charity care (line 21 minus line 22)	638,509	327,568	966,077	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)	7,046,759	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	102,364	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	6,944,395	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,512,489	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,478,566	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,367,888	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		9,558,284	9,558,284	-642,020	8,916,264	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,538,815	4,538,815	0	4,538,815	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	543,956	9,297,060	9,841,016	0	9,841,016	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,159,927	14,950,781	21,110,708	642,020	21,752,728	5.00
7.00	00700	OPERATION OF PLANT	193,398	5,789,330	5,982,728	0	5,982,728	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	634,004	634,004	0	634,004	8.00
9.00	00900	HOUSEKEEPING	0	1,984,299	1,984,299	0	1,984,299	9.00
10.00	01000	DIETARY	0	2,199,343	2,199,343	-1,599,802	599,541	10.00
11.00	01100	CAFETERIA	0	0	0	1,599,802	1,599,802	11.00
13.00	01300	NURSING ADMINISTRATION	1,446,624	244,447	1,691,071	0	1,691,071	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	332,527	44,756	377,283	0	377,283	14.00
15.00	01500	PHARMACY	2,125,375	3,842,908	5,968,283	0	5,968,283	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	254,854	550,995	805,849	0	805,849	16.00
17.00	01700	SOCIAL SERVICE	163,391	87,902	251,293	0	251,293	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,478,135	2,722,340	12,200,475	-1,179,535	11,020,940	30.00
31.00	03100	INTENSIVE CARE UNIT	1,039,243	735,302	1,774,545	0	1,774,545	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,617,041	758,802	3,375,843	0	3,375,843	35.00
43.00	04300	NURSERY	0	0	0	1,179,535	1,179,535	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,865,819	9,835,702	13,701,521	0	13,701,521	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,054,999	1,646,855	3,701,854	0	3,701,854	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,796,145	938,003	2,734,148	0	2,734,148	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	204,301	18,701	223,002	0	223,002	54.02
57.00	05700	CT SCAN	484,951	141,217	626,168	0	626,168	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	381,770	231,436	613,206	0	613,206	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,921,951	2,921,951	0	2,921,951	60.00
65.00	06500	RESPIRATORY THERAPY	1,001,891	199,200	1,201,091	0	1,201,091	65.00
66.00	06600	PHYSICAL THERAPY	372,132	39,671	411,803	0	411,803	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,331	1,253	17,584	0	17,584	68.00
69.00	06900	ELECTROCARDIOLOGY	118,096	169,869	287,965	0	287,965	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	77,971	12,459	90,430	0	90,430	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,792,412	1,792,412	0	1,792,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,057,774	4,057,774	0	4,057,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,638,608	7,104,956	9,743,564	0	9,743,564	75.00
76.00	03330	ENDOSCOPY	1,480,066	1,464,114	2,944,180	0	2,944,180	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,726,115	851,788	2,577,903	0	2,577,903	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,573,666	89,366,729	129,940,395	0	129,940,395	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	92,212	427,353	519,565	0	519,565	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	311,994	75,802	387,796	0	387,796	192.00
194.00	07950	MISSION EFFECTIVENESS	0	6,086	6,086	0	6,086	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	4	4	0	4	194.02
194.04	07954	SCHOOL NURSE	277,003	21,746	298,749	0	298,749	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	4,887,024	-2,337,699	2,549,325	0	2,549,325	194.06
200.00		TOTAL (SUM OF LINES 118-199)	46,141,899	87,560,021	133,701,920	0	133,701,920	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,347,691	7,568,573		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-26,372	4,512,443		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-249,072	9,591,944		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	366,703	22,119,431		5.00
7.00	00700	OPERATION OF PLANT	-278,683	5,704,045		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	634,004		8.00
9.00	00900	HOUSEKEEPING	-329	1,983,970		9.00
10.00	01000	DIETARY	-2,895	596,646		10.00
11.00	01100	CAFETERIA	-503,682	1,096,120		11.00
13.00	01300	NURSING ADMINISTRATION	-551	1,690,520		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	377,283		14.00
15.00	01500	PHARMACY	-10	5,968,273		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-32	805,817		16.00
17.00	01700	SOCIAL SERVICE	0	251,293		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,700,735	9,320,205		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,774,545		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-1,469,552	1,906,291		35.00
43.00	04300	NURSERY	0	1,179,535		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-136	13,701,385		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,219,840	2,482,014		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,334	2,722,814		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	0	223,002		54.02
57.00	05700	CT SCAN	-14,843	611,325		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	613,206		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	2,921,951		60.00
65.00	06500	RESPIRATORY THERAPY	-128	1,200,963		65.00
66.00	06600	PHYSICAL THERAPY	0	411,803		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	17,584		68.00
69.00	06900	ELECTROCARDIOLOGY	0	287,965		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	90,430		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,792,412		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,057,774		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	-90,105	9,653,459		75.00
76.00	03330	ENDOSCOPY	-13,371	2,930,809		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-47,776	2,530,127		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,610,434	123,329,961		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	519,565		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	387,796		192.00
194.00	07950	MISSION EFFECTIVENESS	0	6,086		194.00
194.01	07951	MARKETING	1,865,631	1,865,631		194.01
194.02	07952	JOINT VENTURES	0	4		194.02
194.04	07954	SCHOOL NURSE	0	298,749		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	2,549,325		194.06
200.00		TOTAL (SUM OF LINES 118-199)	-4,744,803	128,957,117		200.00

RECLASSIFICATIONS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/23/2016 10:54 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY					
1.00	NURSERY	43.00	976,121	203,414		1.00
	TOTALS		976,121	203,414		
	B - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	642,020		1.00
	TOTALS		0	642,020		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,599,802		1.00
	TOTALS		0	1,599,802		
500.00	Grand Total: Increases		976,121	2,445,236		500.00

RECLASSIFICATIONS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/23/2016 10:54 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	976,121	203,414	0		1.00
	TOTALS		976,121	203,414			
	B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	642,020	11		1.00
	TOTALS		0	642,020			
	C - CAFETERIA						
1.00	DIETARY	10.00	0	1,599,802	0		1.00
	TOTALS		0	1,599,802			
500.00	Grand Total: Decreases		976,121	2,445,236			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/23/2016 10:54 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,111,746	0	0	0	0	1.00
2.00	Land Improvements	2,267,694	181,971	0	181,971	32,430	2.00
3.00	Buildings and Fixtures	53,800,071	1,031,625	0	1,031,625	9,416	3.00
4.00	Building Improvements	38,615,047	1,102,576	0	1,102,576	1,123,662	4.00
5.00	Fixed Equipment	2,824,791	0	0	0	5,987	5.00
6.00	Movable Equipment	41,474,985	3,516,471	0	3,516,471	1,286,586	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	141,094,334	5,832,643	0	5,832,643	2,458,081	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	141,094,334	5,832,643	0	5,832,643	2,458,081	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,111,746	0	1.00
2.00	Land Improvements	2,417,235	1,877,961	2.00
3.00	Buildings and Fixtures	54,822,280	19,321,863	3.00
4.00	Building Improvements	38,593,961	1,281,787	4.00
5.00	Fixed Equipment	2,818,804	927,614	5.00
6.00	Movable Equipment	43,704,870	19,261,371	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	144,468,896	42,670,596	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	144,468,896	42,670,596	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/23/2016 10:54 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,535,736	5,229,953	642,020	72,598	77,977	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,806,435	700,243	0	2,958	29,179	2.00
3.00	Total (sum of lines 1-2)	7,342,171	5,930,196	642,020	75,556	107,156	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	9,558,284	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,538,815	2.00
3.00	Total (sum of lines 1-2)	0	14,097,099	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/23/2016 10:54 am

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

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: 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	2,893,716	4,599,347	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,806,435	700,243	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,700,151	5,299,590	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	-46,697	72,598	77,977	-28,368	7,568,573	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,958	29,179	-26,372	4,512,443	2.00
3.00	Total (sum of lines 1-2)	-46,697	75,556	107,156	-54,740	12,081,016	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/23/2016 10:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-642,020	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,319,972			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	6,817,481			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-503,183	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	B	-10	PHARMACY	15.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-499	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
34.00	OTHER MISC REVENUE - BENEFITS	B	-7,087	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/23/2016 10:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00	OTHER MISC REVENUE - ADMIN	B	-6,160	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER MISC REVENUE - MAINT	B	-70,856	OPERATION OF PLANT	7.00	0	36.00
37.00	OTHER MISC REVENUE - HKPG	B	-329	HOUSEKEEPING	9.00	0	37.00
38.00	OTHER MISC REVENUE - DIETARY	B	-2,895	DIETARY	10.00	0	38.00
38.01	OTHER MISC REVENUE - MED RECORDS	B	-32	MEDICAL RECORDS & LIBRARY	16.00	0	38.01
39.00	OTHER MISC REVENUE - ROUTINE	B	-142,533	ADULTS & PEDIATRICS	30.00	0	39.00
40.00	OTHER MISC REVENUE - NEONATOLOGY	B	-6	NEONATAL INTENSIVE CARE UNIT	35.00	0	40.00
41.00	OTHER MISC REVENUE - RADIOLOGY	B	-775	RADIOLOGY-DIAGNOSTIC	54.00	0	41.00
42.00	OTHER MISC REVENUE - ASC	B	-90,105	ASC (NON-DISTINCT PART)	75.00	0	42.00
42.01	OTHER MISC REVENUE - ENDO	B	-13,371	ENDOSCOPY	76.00	0	42.01
43.00	PROPERTY RENTAL INCOME	B	-630,606	CAP REL COSTS-BLDG & FIXT	1.00	10	43.00
44.00	PROVIDER ASSESSMENT OFFSET	A	-4,209,925	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	LOBBYING	A	-2,836	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	GAIN ON SALE OF PPE	B	-26,372	CAP REL COSTS-MVBLE EQUIP	2.00	14	46.00
47.00	CONSOLIDATING ENTRY	B	-1,295,420	ADMINISTRATIVE & GENERAL	5.00	0	47.00
49.01	IFUE OPERATING COMFORT IMAGING	B	-28,368	CAP REL COSTS-BLDG & FIXT	1.00	14	49.01
49.05	ENTERTAINMENT EXP - ADMIN	A	-4,131	ADMINISTRATIVE & GENERAL	5.00	0	49.05
49.06	ENTERTAINMENT EXP - NURS ADMIN	A	-551	NURSING ADMINISTRATION	13.00	0	49.06
49.07	ENTERTAINMENT EXP - ROUTINE	A	-718	ADULTS & PEDIATRICS	30.00	0	49.07
49.08	ENTERTAINMENT EXP - RT	A	-128	RESPIRATORY THERAPY	65.00	0	49.08
49.09	ENTERTAINMENT EXP - OR	A	-136	OPERATING ROOM	50.00	0	49.09
49.10	ENTERTAINMENT EXP - RADIOLOGY	A	-59	RADIOLOGY-DIAGNOSTIC	54.00	0	49.10
49.11	ENTERTAINMENT EXP - ER	A	-17	EMERGENCY	91.00	0	49.11
49.12	INCENTIVE PYMT ADJ - SALARIES	A	388,750	ADMINISTRATIVE & GENERAL	5.00	0	49.12
49.13	INCENTIVE PYMT ADJ - FICA	A	48,066	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,744,803				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/23/2016 10:54 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	H.O. COSTS	13,650,529	8,154,104	2.00
3.00	194.01	MARKETING	H.O. COSTS MARKETING	1,865,631	0	3.00
3.01	1.00	CAP REL COSTS-BLDG & FIXT	SVH CHARGEBACK	-3,780	-3,780	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	2,161,794	2,161,794	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	3,913,296	3,913,296	3.03
3.04	7.00	OPERATION OF PLANT	SVH CHARGEBACK	143	143	3.04
3.05	13.00	NURSING ADMINISTRATION	SVH CHARGEBACK	106,641	106,641	3.05
3.06	14.00	CENTRAL SERVICES & SUPPLY	SVH CHARGEBACK	82	82	3.06
3.07	15.00	PHARMACY	SVH CHARGEBACK	-14,105	-14,105	3.07
3.08	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACK	688,883	688,883	3.08
3.09	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACK	-67,098	-67,098	3.09
3.10	31.00	INTENSIVE CARE UNIT	SVH CHARGEBACK	401,864	401,864	3.10
3.11	35.00	NEONATAL INTENSIVE CARE UNIT	SVH CHARGEBACK	980	980	3.11
3.12	50.00	OPERATING ROOM	SVH CHARGEBACK	1,432	1,432	3.12
3.13	52.00	DELIVERY ROOM & LABOR ROOM	SVH CHARGEBACK	652	652	3.13
4.00	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	70,538	70,538	4.00
4.01	54.02	ULTRASOUND	SVH CHARGEBACK	61	61	4.01
4.02	57.00	CT SCAN	SVH CHARGEBACK	184	184	4.02
4.03	58.00	MAGNETIC RESONANCE IMAGING (	SVH CHARGEBACK	143	143	4.03
4.04	65.00	RESPIRATORY THERAPY	SVH CHARGEBACK	512	512	4.04
4.05	66.00	PHYSICAL THERAPY	SVH CHARGEBACK	23,256	23,256	4.05
4.06	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	34,896	34,896	4.06
4.07	70.00	ELECTROENCEPHALOGRAPHY	SVH CHARGEBACK	41	41	4.07
4.08	76.00	ENDOSCOPY	SVH CHARGEBACK	409	409	4.08
4.10	91.00	EMERGENCY	SVH CHARGEBACK	748	748	4.10
4.11	190.00	GIFT, FLOWER, COFFEE SHOP &	SVH CHARGEBACK	25,380	25,380	4.11
4.12	192.00	PHYSICIANS' PRIVATE OFFICES	SVH CHARGEBACK	20	20	4.12
4.13	194.06	SPORTS MEDICINE & OB PHYS	SVH CHARGEBACK	-140,975	-140,975	4.13
4.14	0.00			0	0	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	3,936,201	4,990,991	4.15
4.16	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	595,323	642,020	4.16
4.17	7.00	OPERATION OF PLANT	TRIMEDX	3,641,991	3,849,818	4.17
4.18	4.00	EMPLOYEE BENEFITS DEPARTMENT	PENSION	1,654,429	889,690	4.18
4.20	0.00			0	0	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			32,550,101	25,732,620	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	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	7.00
8.00	A	TRIMEDX	0.00	TRIMEDX	0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-1 Date/Time Prepared: 11/23/2016 10:54 am

				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	

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-1 Date/Time Prepared: 11/23/2016 10:54 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	5,496,425	0		2.00
3.00	1,865,631	0		3.00
3.01	0	9		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
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	9		4.13
4.14	0	0		4.14
4.15	-1,054,790	0		4.15
4.16	-46,697	11		4.16
4.17	-207,827	0		4.17
4.18	764,739	0		4.18
4.20	0	0		4.20
5.00	6,817,481			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOME OFFICE		7.00
8.00	TECHNOLOGY MGMT		8.00
9.00			9.00
10.00			10.00
100.00			100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-1 Date/Time Prepared: 11/23/2016 10:54 am

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/23/2016 10:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,884,334	1,557,484	326,850	211,500	4,920	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	1,469,546	1,469,546	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,109,000	0	1,109,000	246,400	11,360	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	1,219,840	1,219,840	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	10,500	10,500	0	0	0	6.00
7.00	57.00	CT SCAN	14,843	14,843	0	0	0	7.00
8.00	91.00	EMERGENCY	132,664	0	132,664	211,500	835	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			5,840,727	4,272,213	1,568,514		17,115	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	500,279	25,014	0	0	0	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,345,723	67,286	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	84,905	4,245	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,930,907	96,545	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	500,279	0	1,557,484		2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	1,469,546		3.00
4.00	50.00	OPERATING ROOM	0	1,345,723	0	0		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,219,840		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	10,500		6.00
7.00	57.00	CT SCAN	0	0	0	14,843		7.00
8.00	91.00	EMERGENCY	0	84,905	47,759	47,759		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	1,930,907	47,759	4,319,972		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,568,573	7,568,573				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,512,443		4,512,443			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,591,944	99,600	1,149	9,692,693		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,119,431	480,871	605,562	1,309,410	24,515,274	5.00
7.00	00700	OPERATION OF PLANT	5,704,045	884,006	51,698	41,110	6,680,859	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	634,004	42,329	0	0	676,333	8.00
9.00	00900	HOUSEKEEPING	1,983,970	132,537	4,962	0	2,121,469	9.00
10.00	01000	DIETARY	596,646	166,238	4,151	0	767,035	10.00
11.00	01100	CAFETERIA	1,096,120	193,957	11,076	0	1,301,153	11.00
13.00	01300	NURSING ADMINISTRATION	1,690,520	3,487	21,950	307,507	2,023,464	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	377,283	168,605	14,912	70,685	631,485	14.00
15.00	01500	PHARMACY	5,968,273	132,690	198,903	451,789	6,751,655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	805,817	7,712	0	54,174	867,703	16.00
17.00	01700	SOCIAL SERVICE	251,293	18,301	0	34,732	304,326	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,320,205	1,721,154	310,297	1,807,249	13,158,905	30.00
31.00	03100	INTENSIVE CARE UNIT	1,774,545	175,859	69,989	220,911	2,241,304	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,906,291	175,045	4,728	556,302	2,642,366	35.00
43.00	04300	NURSERY	1,179,535	306,259	70,990	207,493	1,764,277	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,701,385	674,828	1,526,463	821,753	16,724,429	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,482,014	358,464	44,364	436,829	3,321,671	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,722,814	374,144	283,103	381,805	3,761,866	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	223,002	9,672	58,228	43,428	334,330	54.02
57.00	05700	CT SCAN	611,325	85,677	69,679	103,086	869,767	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	613,206	202,815	303,154	81,152	1,200,327	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,921,951	122,865	15,474	0	3,060,290	60.00
65.00	06500	RESPIRATORY THERAPY	1,200,963	51,289	75,876	212,971	1,541,099	65.00
66.00	06600	PHYSICAL THERAPY	411,803	49,889	661	79,104	541,457	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,584	2,138	0	3,471	23,193	68.00
69.00	06900	ELECTROCARDIOLOGY	287,965	12,294	18,191	25,104	343,554	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	90,430	3,869	14,726	16,574	125,599	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,792,412	0	0	0	1,792,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,057,774	0	0	0	4,057,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	9,653,459	322,676	242,911	560,886	10,779,932	75.00
76.00	03330	ENDOSCOPY	2,930,809	133,912	313,178	314,616	3,692,515	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,530,127	346,552	61,395	366,919	3,304,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	123,329,961	7,459,734	4,397,770	8,509,060	121,922,816	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	519,565	42,100	9,386	19,601	590,652	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	387,796	0	0	66,320	454,116	192.00
194.00	07950	MISSION EFFECTIVENESS	6,086	0	0	0	6,086	194.00
194.01	07951	MARKETING	1,865,631	0	0	0	1,865,631	194.01
194.02	07952	JOINT VENTURES	4	0	0	0	4	194.02
194.04	07954	SCHOOL NURSE	298,749	22,526	658	58,882	380,815	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	2,549,325	44,213	104,629	1,038,830	3,736,997	194.06
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	128,957,117	7,568,573	4,512,443	9,692,693	128,957,117	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,515,274					5.00
7.00	00700	OPERATION OF PLANT	1,568,178	8,249,037				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	158,754	57,204	892,291			8.00
9.00	00900	HOUSEKEEPING	497,966	179,110	0	2,798,545		9.00
10.00	01000	DIETARY	180,044	224,653	0	78,463	1,250,195	10.00
11.00	01100	CAFETERIA	305,416	262,112	0	91,546	0	11.00
13.00	01300	NURSING ADMINISTRATION	474,962	4,713	0	1,646	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	148,227	227,852	25,517	79,580	0	14.00
15.00	01500	PHARMACY	1,584,796	179,316	0	62,629	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	203,673	10,423	0	3,640	0	16.00
17.00	01700	SOCIAL SERVICE	71,434	24,732	0	8,638	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,088,750	2,325,954	267,914	812,370	1,128,421	30.00
31.00	03100	INTENSIVE CARE UNIT	526,095	237,655	34,750	83,004	50,419	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	620,235	236,555	0	82,620	0	35.00
43.00	04300	NURSERY	414,123	413,876	41,203	144,551	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,925,626	911,958	105,986	318,513	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	779,686	484,426	89,560	169,192	71,355	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	883,012	505,615	18,737	176,593	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	78,476	13,071	1,727	4,565	0	54.02
57.00	05700	CT SCAN	204,158	115,783	4,802	40,439	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	281,749	274,083	70,548	95,727	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	718,333	166,039	0	57,991	0	60.00
65.00	06500	RESPIRATORY THERAPY	361,738	69,312	750	24,208	0	65.00
66.00	06600	PHYSICAL THERAPY	127,095	67,420	1,602	23,547	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,444	2,889	117	1,009	0	68.00
69.00	06900	ELECTROCARDIOLOGY	80,641	16,614	179	5,803	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,481	5,228	56	1,826	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	420,727	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	952,469	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,530,341	436,063	47,974	152,300	0	75.00
76.00	03330	ENDOSCOPY	866,733	180,968	42,576	63,205	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	775,771	468,328	132,031	163,569	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,864,133	8,101,952	886,029	2,747,174	1,250,195	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	138,642	56,894	0	19,871	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	106,593	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	1,429	0	0	0	0	194.00
194.01	07951	MARKETING	437,914	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	1	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	89,388	30,442	0	10,632	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	877,174	59,749	6,262	20,868	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,515,274	8,249,037	892,291	2,798,545	1,250,195	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,960,227					11.00
13.00	01300	NURSING ADMINISTRATION	57,817	2,562,602				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,305	0	1,141,966			14.00
15.00	01500	PHARMACY	92,790	0	6,298	8,677,484		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,127	0	0	0	1,111,566	16.00
17.00	01700	SOCIAL SERVICE	8,495	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	428,960	830,661	24,181	13,920	108,333	30.00
31.00	03100	INTENSIVE CARE UNIT	48,883	94,660	6,140	2,364	12,410	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	74,413	144,097	5,407	4,375	27,194	35.00
43.00	04300	NURSERY	56,330	109,081	0	0	18,107	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	212,197	410,909	467,374	477,034	320,743	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	103,249	199,937	22,469	19,126	70,467	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,615	0	23,546	27,433	53,432	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	7,305	0	161	0	7,228	54.02
57.00	05700	CT SCAN	23,863	0	2,038	0	19,205	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,495	0	1,284	1,177	9,095	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	86,536	76,036	60.00
65.00	06500	RESPIRATORY THERAPY	56,542	0	3,486	5,802	8,099	65.00
66.00	06600	PHYSICAL THERAPY	20,854	0	14,088	417	5,533	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	815	0	0	0	300	68.00
69.00	06900	ELECTROCARDIOLOGY	7,469	0	12	0	7,481	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,106	0	343	77	6,136	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	106,847	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	241,888	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,251,001	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	167,154	0	168,616	703,800	188,081	75.00
76.00	03330	ENDOSCOPY	72,122	139,660	24,139	53,052	73,512	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	84,255	163,155	16,952	17,486	100,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,717,161	2,092,160	1,135,269	8,663,600	1,111,566	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,370	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,029	0	24	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	45,067	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	219,667	425,375	6,673	13,884	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,960,227	2,562,602	1,141,966	8,677,484	1,111,566	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	417,625					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93,737	22,282,106	0	22,282,106		30.00
31.00	03100	INTENSIVE CARE UNIT	42,856	3,380,540	0	3,380,540		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	69,574	3,906,836	0	3,906,836		35.00
43.00	04300	NURSERY	0	2,961,548	0	2,961,548		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,205	23,882,974	0	23,882,974		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,834	5,383,972	0	5,383,972		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,560,849	0	5,560,849		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	446,863	0	446,863		54.02
57.00	05700	CT SCAN	0	1,280,055	0	1,280,055		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,957,485	0	1,957,485		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	4,165,225	0	4,165,225		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,071,036	0	2,071,036		65.00
66.00	06600	PHYSICAL THERAPY	0	802,013	0	802,013		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	33,767	0	33,767		68.00
69.00	06900	ELECTROCARDIOLOGY	0	461,753	0	461,753		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	172,852	0	172,852		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,319,986	0	2,319,986		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,252,131	0	5,252,131		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,251,001	0	7,251,001		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	15,174,261	0	15,174,261		75.00
76.00	03330	ENDOSCOPY	21,879	5,230,361	0	5,230,361		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	106,631	5,333,345	0	5,333,345		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	395,716	119,310,959	0	119,310,959		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	815,429	0	815,429		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,909	596,671	0	596,671		192.00
194.00	07950	MISSION EFFECTIVENESS	0	7,515	0	7,515		194.00
194.01	07951	MARKETING	0	2,303,545	0	2,303,545		194.01
194.02	07952	JOINT VENTURES	0	5	0	5		194.02
194.04	07954	SCHOOL NURSE	0	556,344	0	556,344		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	5,366,649	0	5,366,649		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	417,625	128,957,117	0	128,957,117		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	99,600	1,149	100,749	100,749	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,250,439	480,871	605,562	3,336,872	13,613	5.00
7.00	00700	OPERATION OF PLANT	0	884,006	51,698	935,704	427	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	42,329	0	42,329	0	8.00
9.00	00900	HOUSEKEEPING	0	132,537	4,962	137,499	0	9.00
10.00	01000	DIETARY	0	166,238	4,151	170,389	0	10.00
11.00	01100	CAFETERIA	0	193,957	11,076	205,033	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,487	21,950	25,437	3,197	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	168,605	14,912	183,517	735	14.00
15.00	01500	PHARMACY	0	132,690	198,903	331,593	4,697	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,712	0	7,712	563	16.00
17.00	01700	SOCIAL SERVICE	0	18,301	0	18,301	361	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,721,154	310,297	2,031,451	18,768	30.00
31.00	03100	INTENSIVE CARE UNIT	0	175,859	69,989	245,848	2,297	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	175,045	4,728	179,773	5,784	35.00
43.00	04300	NURSERY	0	306,259	70,990	377,249	2,157	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	674,828	1,526,463	2,201,291	8,543	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	358,464	44,364	402,828	4,542	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	374,144	283,103	657,247	3,969	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	9,672	58,228	67,900	452	54.02
57.00	05700	CT SCAN	0	85,677	69,679	155,356	1,072	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	202,815	303,154	505,969	844	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	122,865	15,474	138,339	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	51,289	75,876	127,165	2,214	65.00
66.00	06600	PHYSICAL THERAPY	0	49,889	661	50,550	822	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,138	0	2,138	36	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,294	18,191	30,485	261	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,869	14,726	18,595	172	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	322,676	242,911	565,587	5,831	75.00
76.00	03330	ENDOSCOPY	0	133,912	313,178	447,090	3,271	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	346,552	61,395	407,947	3,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,250,439	7,459,734	4,397,770	14,107,943	88,443	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42,100	9,386	51,486	204	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	690	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	22,526	658	23,184	612	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	44,213	104,629	148,842	10,800	194.06
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,250,439	7,568,573	4,512,443	14,331,455	100,749	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,350,485					5.00
7.00	00700	OPERATION OF PLANT	214,322	1,150,453				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,697	7,978	72,004			8.00
9.00	00900	HOUSEKEEPING	68,057	24,980	0	230,536		9.00
10.00	01000	DIETARY	24,606	31,331	0	6,464	232,790	10.00
11.00	01100	CAFETERIA	41,741	36,556	0	7,541	0	11.00
13.00	01300	NURSING ADMINISTRATION	64,913	657	0	136	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,258	31,777	2,059	6,556	0	14.00
15.00	01500	PHARMACY	216,593	25,008	0	5,159	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,836	1,454	0	300	0	16.00
17.00	01700	SOCIAL SERVICE	9,763	3,449	0	712	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	422,138	324,387	21,620	66,919	210,116	30.00
31.00	03100	INTENSIVE CARE UNIT	71,901	33,145	2,804	6,838	9,388	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	84,767	32,991	0	6,806	0	35.00
43.00	04300	NURSERY	56,598	57,721	3,325	11,908	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	536,512	127,186	8,553	26,238	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	106,559	67,561	7,227	13,938	13,286	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,681	70,516	1,512	14,547	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	10,725	1,823	139	376	0	54.02
57.00	05700	CT SCAN	27,902	16,148	388	3,331	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	38,506	38,225	5,693	7,886	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	98,174	23,157	0	4,777	0	60.00
65.00	06500	RESPIRATORY THERAPY	49,438	9,667	61	1,994	0	65.00
66.00	06600	PHYSICAL THERAPY	17,370	9,403	129	1,940	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	744	403	9	83	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,021	2,317	14	478	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,029	729	5	150	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,501	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	130,173	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	345,820	60,816	3,871	12,546	0	75.00
76.00	03330	ENDOSCOPY	118,456	25,239	3,436	5,207	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	106,024	65,315	10,654	13,474	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,124,825	1,129,939	71,499	226,304	232,790	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,948	7,935	0	1,637	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,568	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	195	0	0	0	0	194.00
194.01	07951	MARKETING	59,849	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	12,217	4,246	0	876	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	119,883	8,333	505	1,719	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,350,485	1,150,453	72,004	230,536	232,790	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	290,871					11.00
13.00	01300	NURSING ADMINISTRATION	8,579	102,919				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,348	0	249,250			14.00
15.00	01500	PHARMACY	13,769	0	1,375	598,194		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,877	0	0	0	41,742	16.00
17.00	01700	SOCIAL SERVICE	1,261	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,651	33,360	5,278	960	4,080	30.00
31.00	03100	INTENSIVE CARE UNIT	7,254	3,802	1,340	163	467	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,042	5,787	1,180	302	1,024	35.00
43.00	04300	NURSERY	8,359	4,381	0	0	682	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,487	16,503	102,010	32,885	11,962	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,321	8,030	4,904	1,318	2,654	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,414	0	5,139	1,891	2,012	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	1,084	0	35	0	272	54.02
57.00	05700	CT SCAN	3,541	0	445	0	723	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,486	0	280	81	343	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	5,965	2,863	60.00
65.00	06500	RESPIRATORY THERAPY	8,390	0	761	400	305	65.00
66.00	06600	PHYSICAL THERAPY	3,095	0	3,075	29	208	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	121	0	0	0	11	68.00
69.00	06900	ELECTROCARDIOLOGY	1,108	0	3	0	282	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	609	0	75	5	231	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	23,321	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	52,796	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	499,859	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	24,803	0	36,803	48,517	7,083	75.00
76.00	03330	ENDOSCOPY	10,702	5,609	5,269	3,657	2,768	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	12,502	6,553	3,700	1,205	3,772	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	254,803	84,025	247,789	597,237	41,742	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,390	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,082	0	5	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	1,810	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	32,596	17,084	1,456	957	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	290,871	102,919	249,250	598,194	41,742	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	33,847					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,597	3,210,325	0	3,210,325		30.00
31.00	03100	INTENSIVE CARE UNIT	3,473	388,720	0	388,720		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	5,639	335,095	0	335,095		35.00
43.00	04300	NURSERY	0	522,380	0	522,380		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	665	3,103,835	0	3,103,835		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,282	652,450	0	652,450		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	893,928	0	893,928		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	82,806	0	82,806		54.02
57.00	05700	CT SCAN	0	208,906	0	208,906		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	601,313	0	601,313		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	273,275	0	273,275		60.00
65.00	06500	RESPIRATORY THERAPY	0	200,395	0	200,395		65.00
66.00	06600	PHYSICAL THERAPY	0	86,621	0	86,621		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	3,545	0	3,545		68.00
69.00	06900	ELECTROCARDIOLOGY	0	45,969	0	45,969		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	24,600	0	24,600		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	80,822	0	80,822		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	182,969	0	182,969		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	499,859	0	499,859		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,111,677	0	1,111,677		75.00
76.00	03330	ENDOSCOPY	1,773	632,477	0	632,477		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,642	643,603	0	643,603		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,071	13,785,570	0	13,785,570		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	81,600	0	81,600		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,776	19,121	0	19,121		192.00
194.00	07950	MISSION EFFECTIVENESS	0	195	0	195		194.00
194.01	07951	MARKETING	0	59,849	0	59,849		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	42,945	0	42,945		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	342,175	0	342,175		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	33,847	14,331,455	0	14,331,455		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	297,347					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,361,600				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,913	1,111	45,597,943			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,892	585,319	6,159,927	-24,515,274	104,441,843	5.00
7.00	00700	OPERATION OF PLANT	34,730	49,970	193,398	0	6,680,859	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,663	0	0	0	676,333	8.00
9.00	00900	HOUSEKEEPING	5,207	4,796	0	0	2,121,469	9.00
10.00	01000	DIETARY	6,531	4,012	0	0	767,035	10.00
11.00	01100	CAFETERIA	7,620	10,706	0	0	1,301,153	11.00
13.00	01300	NURSING ADMINISTRATION	137	21,216	1,446,624	0	2,023,464	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	14,414	332,527	0	631,485	14.00
15.00	01500	PHARMACY	5,213	192,254	2,125,375	0	6,751,655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	254,854	0	867,703	16.00
17.00	01700	SOCIAL SERVICE	719	0	163,391	0	304,326	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,619	299,924	8,502,014	0	13,158,905	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	67,649	1,039,243	0	2,241,304	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	4,570	2,617,041	0	2,642,366	35.00
43.00	04300	NURSERY	12,032	68,617	976,121	0	1,764,277	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	1,475,435	3,865,819	0	16,724,429	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	42,881	2,054,999	0	3,321,671	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,699	273,639	1,796,145	0	3,761,866	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	380	56,282	204,301	0	334,330	54.02
57.00	05700	CT SCAN	3,366	67,350	484,951	0	869,767	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	293,020	381,770	0	1,200,327	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	14,957	0	0	3,060,290	60.00
65.00	06500	RESPIRATORY THERAPY	2,015	73,340	1,001,891	0	1,541,099	65.00
66.00	06600	PHYSICAL THERAPY	1,960	639	372,132	0	541,457	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	0	16,331	0	23,193	68.00
69.00	06900	ELECTROCARDIOLOGY	483	17,583	118,096	0	343,554	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	152	14,234	77,971	0	125,599	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,792,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,057,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	234,791	2,638,608	0	10,779,932	75.00
76.00	03330	ENDOSCOPY	5,261	302,709	1,480,066	0	3,692,515	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	59,343	1,726,115	0	3,304,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	293,071	4,250,761	40,029,710	-24,515,274	97,407,542	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	9,072	92,212	0	590,652	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	311,994	0	454,116	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	6,086	194.00
194.01	07951	MARKETING	0	0	0	0	1,865,631	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	4	194.02
194.04	07954	SCHOOL NURSE	885	636	277,003	0	380,815	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,737	101,131	4,887,024	0	3,736,997	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,568,573	4,512,443	9,692,693		24,515,274	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.453672	1.034584	0.212569		0.234727	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			100,749		3,350,485	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002210		0.032080	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	239,812					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,663	494,597				8.00
9.00	00900	HOUSEKEEPING	5,207	0	232,942			9.00
10.00	01000	DIETARY	6,531	0	6,531	46,220		10.00
11.00	01100	CAFETERIA	7,620	0	7,620	0	1,091,851	11.00
13.00	01300	NURSING ADMINISTRATION	137	0	137	0	32,204	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	14,144	6,624	0	16,323	14.00
15.00	01500	PHARMACY	5,213	0	5,213	0	51,684	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	303	0	14,553	16.00
17.00	01700	SOCIAL SERVICE	719	0	719	0	4,732	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,619	148,504	67,619	41,718	238,932	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	19,262	6,909	1,864	27,228	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	0	6,877	0	41,448	35.00
43.00	04300	NURSERY	12,032	22,839	12,032	0	31,376	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	58,748	26,512	0	118,194	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	49,643	14,083	2,638	57,510	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,699	10,386	14,699	0	61,613	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	380	957	380	0	4,069	54.02
57.00	05700	CT SCAN	3,366	2,662	3,366	0	13,292	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	39,105	7,968	0	13,087	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	0	4,827	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,015	416	2,015	0	31,494	65.00
66.00	06600	PHYSICAL THERAPY	1,960	888	1,960	0	11,616	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	65	84	0	454	68.00
69.00	06900	ELECTROCARDIOLOGY	483	99	483	0	4,160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	152	31	152	0	2,287	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	26,592	12,677	0	93,105	75.00
76.00	03330	ENDOSCOPY	5,261	23,600	5,261	0	40,172	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	73,185	13,615	0	46,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	235,536	491,126	228,666	46,220	956,463	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	1,654	0	5,219	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	7,814	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	885	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,737	3,471	1,737	0	122,355	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,249,037	892,291	2,798,545	1,250,195	1,960,227	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.397933	1.804077	12.013913	27.048788	1.795325	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,150,453	72,004	230,536	232,790	290,871	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.797312	0.145581	0.989671	5.036564	0.266402	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/23/2016 10:54 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	737,108					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,157,017				14.00
15.00	01500	PHARMACY	0	105,646	3,391,851			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	454,914,095		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	13,896	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	238,932	405,640	5,441	44,344,175	3,119	30.00
31.00	03100	INTENSIVE CARE UNIT	27,228	102,998	924	5,079,996	1,426	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	41,448	90,711	1,710	11,131,240	2,315	35.00
43.00	04300	NURSERY	31,376	0	0	7,411,829	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	118,194	7,840,460	186,463	131,204,615	273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,510	376,928	7,476	28,844,318	1,758	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	394,991	10,723	21,871,538	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	2,698	0	2,958,758	0	54.02
57.00	05700	CT SCAN	0	34,196	0	7,861,037	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	21,547	460	3,722,979	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	33,825	31,124,178	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	58,480	2,268	3,315,092	0	65.00
66.00	06600	PHYSICAL THERAPY	0	236,337	163	2,264,750	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	122,610	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	196	0	3,062,292	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,747	30	2,511,666	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,792,412	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,057,774	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,834,268	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	2,828,603	275,101	76,987,837	0	75.00
76.00	03330	ENDOSCOPY	40,172	404,944	20,737	30,090,755	728	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	46,930	284,374	6,835	41,004,430	3,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	601,790	19,044,682	3,386,424	454,914,095	13,167	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	398	0	0	729	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	12,963	0	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	122,355	111,937	5,427	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,562,602	1,141,966	8,677,484	1,111,566	417,625	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.476562	0.059611	2.558333	0.002443	30.053613	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	102,919	249,250	598,194	41,742	33,847	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.139625	0.013011	0.176362	0.000092	2.435737	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,282,106		22,282,106	0	22,282,106	30.00
31.00	03100	INTENSIVE CARE UNIT	3,380,540		3,380,540	0	3,380,540	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,906,836		3,906,836	0	3,906,836	35.00
43.00	04300	NURSERY	2,961,548		2,961,548	0	2,961,548	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,882,974		23,882,974	0	23,882,974	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,383,972		5,383,972	0	5,383,972	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,560,849		5,560,849	0	5,560,849	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	446,863		446,863	0	446,863	54.02
57.00	05700	CT SCAN	1,280,055		1,280,055	0	1,280,055	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,957,485		1,957,485	0	1,957,485	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,165,225		4,165,225	0	4,165,225	60.00
65.00	06500	RESPIRATORY THERAPY	2,071,036	0	2,071,036	0	2,071,036	65.00
66.00	06600	PHYSICAL THERAPY	802,013	0	802,013	0	802,013	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	33,767	0	33,767	0	33,767	68.00
69.00	06900	ELECTROCARDIOLOGY	461,753		461,753	0	461,753	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	172,852		172,852	0	172,852	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,319,986		2,319,986	0	2,319,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,252,131		5,252,131	0	5,252,131	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,251,001		7,251,001	0	7,251,001	73.00
75.00	07500	ASC (NON-DISTINCT PART)	15,174,261		15,174,261	0	15,174,261	75.00
76.00	03330	ENDOSCOPY	5,230,361		5,230,361	0	5,230,361	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,333,345		5,333,345	47,759	5,381,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,650,628		2,650,628		2,650,628	92.00
200.00		Subtotal (see instructions)	121,961,587	0	121,961,587	47,759	122,009,346	200.00
201.00		Less Observation Beds	2,650,628		2,650,628		2,650,628	201.00
202.00		Total (see instructions)	119,310,959	0	119,310,959	47,759	119,358,718	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,521,917		35,521,917			30.00
31.00	03100	INTENSIVE CARE UNIT	5,079,996		5,079,996			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,131,240		11,131,240			35.00
43.00	04300	NURSERY	7,411,829		7,411,829			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,082,714	72,121,901	131,204,615	0.182028	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,007,960	836,358	28,844,318	0.186656	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,159,350	19,712,187	21,871,537	0.254250	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	369,427	2,589,331	2,958,758	0.151031	0.000000	54.02
57.00	05700	CT SCAN	1,369,124	6,491,913	7,861,037	0.162835	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	223,018	3,499,961	3,722,979	0.525785	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	13,041,820	18,082,358	31,124,178	0.133826	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,469,936	845,156	3,315,092	0.624730	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,235,897	1,028,853	2,264,750	0.354129	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	83,506	39,104	122,610	0.275402	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	888,081	2,174,211	3,062,292	0.150787	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,029,874	481,792	2,511,666	0.068820	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,824,742	22,713,913	38,538,655	0.060199	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,072,127	3,471,625	23,543,752	0.223080	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,294,583	12,509,158	30,803,741	0.235394	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	76,987,837	76,987,837	0.197099	0.000000	75.00
76.00	03330	ENDOSCOPY	1,352,704	28,738,051	30,090,755	0.173820	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,746,008	35,258,422	41,004,430	0.130068	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,043,932	7,778,326	8,822,258	0.300448	0.000000	92.00
200.00		Subtotal (see instructions)	232,439,785	315,360,457	547,800,242			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	232,439,785	315,360,457	547,800,242			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.182028	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.186656	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.254250	54.00
54.01	03480	ONCOLOGY	0.000000	54.01
54.02	05402	ULTRASOUND	0.151031	54.02
57.00	05700	CT SCAN	0.162835	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.525785	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.133826	60.00
65.00	06500	RESPIRATORY THERAPY	0.624730	65.00
66.00	06600	PHYSICAL THERAPY	0.354129	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.275402	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150787	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.068820	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.060199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.223080	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235394	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.197099	75.00
76.00	03330	ENDOSCOPY	0.173820	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.131232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.300448	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/23/2016 10:54 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,282,106		22,282,106	0	22,282,106	30.00
31.00	03100	INTENSIVE CARE UNIT	3,380,540		3,380,540	0	3,380,540	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,906,836		3,906,836	0	3,906,836	35.00
43.00	04300	NURSERY	2,961,548		2,961,548	0	2,961,548	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,882,974		23,882,974	0	23,882,974	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,383,972		5,383,972	0	5,383,972	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,560,849		5,560,849	0	5,560,849	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	446,863		446,863	0	446,863	54.02
57.00	05700	CT SCAN	1,280,055		1,280,055	0	1,280,055	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,957,485		1,957,485	0	1,957,485	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,165,225		4,165,225	0	4,165,225	60.00
65.00	06500	RESPIRATORY THERAPY	2,071,036	0	2,071,036	0	2,071,036	65.00
66.00	06600	PHYSICAL THERAPY	802,013	0	802,013	0	802,013	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	33,767	0	33,767	0	33,767	68.00
69.00	06900	ELECTROCARDIOLOGY	461,753		461,753	0	461,753	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	172,852		172,852	0	172,852	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,319,986		2,319,986	0	2,319,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,252,131		5,252,131	0	5,252,131	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,251,001		7,251,001	0	7,251,001	73.00
75.00	07500	ASC (NON-DISTINCT PART)	15,174,261		15,174,261	0	15,174,261	75.00
76.00	03330	ENDOSCOPY	5,230,361		5,230,361	0	5,230,361	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,333,345		5,333,345	47,759	5,381,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,650,628		2,650,628		2,650,628	92.00
200.00		Subtotal (see instructions)	121,961,587	0	121,961,587	47,759	122,009,346	200.00
201.00		Less Observation Beds	2,650,628		2,650,628		2,650,628	201.00
202.00		Total (see instructions)	119,310,959	0	119,310,959	47,759	119,358,718	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/23/2016 10:54 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,521,917		35,521,917			30.00
31.00	03100	INTENSIVE CARE UNIT	5,079,996		5,079,996			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,131,240		11,131,240			35.00
43.00	04300	NURSERY	7,411,829		7,411,829			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,082,714	72,121,901	131,204,615	0.182028	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,007,960	836,358	28,844,318	0.186656	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,159,350	19,712,187	21,871,537	0.254250	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	369,427	2,589,331	2,958,758	0.151031	0.000000	54.02
57.00	05700	CT SCAN	1,369,124	6,491,913	7,861,037	0.162835	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	223,018	3,499,961	3,722,979	0.525785	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	13,041,820	18,082,358	31,124,178	0.133826	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,469,936	845,156	3,315,092	0.624730	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,235,897	1,028,853	2,264,750	0.354129	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	83,506	39,104	122,610	0.275402	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	888,081	2,174,211	3,062,292	0.150787	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,029,874	481,792	2,511,666	0.068820	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,824,742	22,713,913	38,538,655	0.060199	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,072,127	3,471,625	23,543,752	0.223080	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,294,583	12,509,158	30,803,741	0.235394	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	76,987,837	76,987,837	0.197099	0.000000	75.00
76.00	03330	ENDOSCOPY	1,352,704	28,738,051	30,090,755	0.173820	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,746,008	35,258,422	41,004,430	0.130068	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,043,932	7,778,326	8,822,258	0.300448	0.000000	92.00
200.00		Subtotal (see instructions)	232,439,785	315,360,457	547,800,242			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	232,439,785	315,360,457	547,800,242			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/23/2016 10:54 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03480	ONCOLOGY	0.000000		54.01
54.02	05402	ULTRASOUND	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03330	ENDOSCOPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,210,325	0	3,210,325	14,896	215.52	30.00
31.00	INTENSIVE CARE UNIT	388,720		388,720	922	421.61	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	335,095		335,095	1,812	184.93	35.00
43.00	NURSERY	522,380		522,380	3,334	156.68	43.00
200.00	Total (lines 30-199)	4,456,520		4,456,520	20,964		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	4,437	956,262	30.00
31.00	INTENSIVE CARE UNIT	386	162,741	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0	35.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	4,823	1,119,003	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,103,835	131,204,615	0.023656	21,013,191	497,088	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	652,450	28,844,318	0.022620	24,817	561	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	893,928	21,871,537	0.040872	616,137	25,183	54.00
54.01	03480	ONCOLOGY	0	0	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	82,806	2,958,758	0.027987	57,886	1,620	54.02
57.00	05700	CT SCAN	208,906	7,861,037	0.026575	585,650	15,564	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	601,313	3,722,979	0.161514	76,950	12,429	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	273,275	31,124,178	0.008780	4,345,460	38,153	60.00
65.00	06500	RESPIRATORY THERAPY	200,395	3,315,092	0.060449	1,116,782	67,508	65.00
66.00	06600	PHYSICAL THERAPY	86,621	2,264,750	0.038247	795,415	30,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,545	122,610	0.028913	47,314	1,368	68.00
69.00	06900	ELECTROCARDIOLOGY	45,969	3,062,292	0.015011	396,495	5,952	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,600	2,511,666	0.009794	956,181	9,365	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	80,822	38,538,655	0.002097	4,522,431	9,484	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	182,969	23,543,752	0.007771	8,649,645	67,216	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	499,859	30,803,741	0.016227	5,455,997	88,534	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,111,677	76,987,837	0.014440	0	0	75.00
76.00	03330	ENDOSCOPY	632,477	30,090,755	0.021019	457,367	9,613	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	643,603	41,004,430	0.015696	2,445,218	38,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	381,892	8,822,258	0.043287	431,700	18,687	92.00
200.00		Total (lines 50-199)	9,710,942	488,655,260		51,994,636	937,127	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,896	0.00	4,437	0		30.00
31.00	03100	INTENSIVE CARE UNIT	922	0.00	386	0		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,812	0.00	0	0		35.00
43.00	04300	NURSERY	3,334	0.00	0	0		43.00
200.00		Total (lines 30-199)	20,964		4,823	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	131,204,615	0.000000	0.000000	21,013,191	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,844,318	0.000000	0.000000	24,817	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,871,537	0.000000	0.000000	616,137	54.00
54.01	03480	ONCOLOGY	0	0	0.000000	0.000000	0	54.01
54.02	05402	ULTRASOUND	0	2,958,758	0.000000	0.000000	57,886	54.02
57.00	05700	CT SCAN	0	7,861,037	0.000000	0.000000	585,650	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,722,979	0.000000	0.000000	76,950	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	31,124,178	0.000000	0.000000	4,345,460	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,315,092	0.000000	0.000000	1,116,782	65.00
66.00	06600	PHYSICAL THERAPY	0	2,264,750	0.000000	0.000000	795,415	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	122,610	0.000000	0.000000	47,314	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,062,292	0.000000	0.000000	396,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,511,666	0.000000	0.000000	956,181	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,538,655	0.000000	0.000000	4,522,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,543,752	0.000000	0.000000	8,649,645	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30,803,741	0.000000	0.000000	5,455,997	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	76,987,837	0.000000	0.000000	0	75.00
76.00	03330	ENDOSCOPY	0	30,090,755	0.000000	0.000000	457,367	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	41,004,430	0.000000	0.000000	2,445,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,822,258	0.000000	0.000000	431,700	92.00
200.00		Total (lines 50-199)	0	488,655,260			51,994,636	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	10,005,919	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,041	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,549,005	0		54.00
54.01	03480	ONCOLOGY	0	0	0		54.01
54.02	05402	ULTRASOUND	0	355,177	0		54.02
57.00	05700	CT SCAN	0	1,681,721	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	797,600	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	4,445,506	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	308,215	0		65.00
66.00	06600	PHYSICAL THERAPY	0	38,209	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	569,224	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	61,407	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,561,727	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	387,404	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,873,075	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03330	ENDOSCOPY	0	3,027,513	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	6,743,752	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,337,426	0		92.00
200.00		Total (lines 50-199)	0	35,746,921	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.182028	10,005,919	0	0	1,821,357	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.186656	4,041	0	0	754	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.254250	1,549,005	154	0	393,835	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.151031	355,177	0	0	53,643	54.02
57.00	05700	CT SCAN	0.162835	1,681,721	0	0	273,843	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.525785	797,600	0	0	419,366	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.133826	4,445,506	0	0	594,924	60.00
65.00	06500	RESPIRATORY THERAPY	0.624730	308,215	0	0	192,551	65.00
66.00	06600	PHYSICAL THERAPY	0.354129	38,209	0	0	13,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.275402	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150787	569,224	0	0	85,832	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.068820	61,407	0	0	4,226	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.060199	1,561,727	503	0	94,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.223080	387,404	0	0	86,422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235394	1,873,075	0	31,299	440,911	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.197099	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.173820	3,027,513	0	0	526,242	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.130068	6,743,752	0	0	877,146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.300448	2,337,426	0	200	702,275	92.00
200.00		Subtotal (see instructions)		35,746,921	657	31,499	6,580,872	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		35,746,921	657	31,499	6,580,872	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39	0		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	0	0		54.02
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,368		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03330	ENDOSCOPY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	60		92.00
200.00		Subtotal (see instructions)	69	7,428		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	69	7,428		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,896	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,896	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)	13,124	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)	4,437	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)	22,282,106	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)	22,282,106	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)	22,282,106	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,495.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,637,042	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)	6,637,042	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,380,540	922	3,666.53	386	1,415,281	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	3,906,836	1,812	2,156.09	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	9,846,575	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	17,898,898	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,119,003	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	937,127	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,056,130	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,842,768	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,772	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,495.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,650,628	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,210,325	22,282,106	0.144076	2,650,628	381,892	90.00
91.00	Nursing School cost	0	22,282,106	0.000000	2,650,628	0	91.00
92.00	Allied health cost	0	22,282,106	0.000000	2,650,628	0	92.00
93.00	All other Medical Education	0	22,282,106	0.000000	2,650,628	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/23/2016 10:54 am

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,896	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,896	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)	13,124	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)	95	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	3,334	15.00
16.00	Nursery days (title V or XIX only)	79	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)	22,282,106	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)	22,282,106	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)	22,282,106	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,495.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	142,105	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)	142,105	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/23/2016 10:54 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,961,548	3,334	888.29	79	70,175	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,380,540	922	3,666.53	46	168,660	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	3,906,836	1,812	2,156.09	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,538,932	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,919,872	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)	1,772	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,495.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,650,628	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/23/2016 10:54 am

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	3,210,325	22,282,106	0.144076	2,650,628	381,892	90.00
91.00	Nursing School cost	0	22,282,106	0.000000	2,650,628	0	91.00
92.00	Allied health cost	0	22,282,106	0.000000	2,650,628	0	92.00
93.00	All other Medical Education	0	22,282,106	0.000000	2,650,628	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		8,298,320		30.00
31.00	03100	INTENSIVE CARE UNIT		4,095,139		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0		35.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.182028	21,013,191	3,824,989	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.186656	24,817	4,632	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.254250	616,137	156,653	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.151031	57,886	8,743	54.02
57.00	05700	CT SCAN	0.162835	585,650	95,364	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.525785	76,950	40,459	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.133826	4,345,460	581,536	60.00
65.00	06500	RESPIRATORY THERAPY	0.624730	1,116,782	697,687	65.00
66.00	06600	PHYSICAL THERAPY	0.354129	795,415	281,680	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.275402	47,314	13,030	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150787	396,495	59,786	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.068820	956,181	65,804	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.060199	4,522,431	272,246	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.223080	8,649,645	1,929,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235394	5,455,997	1,284,309	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.197099	0	0	75.00
76.00	03330	ENDOSCOPY	0.173820	457,367	79,500	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.131232	2,445,218	320,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.300448	431,700	129,703	92.00
200.00		Total (sum of lines 50-94 and 96-98)		51,994,636	9,846,575	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)		51,994,636		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/23/2016 10:54 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,357,430		30.00
31.00	03100	INTENSIVE CARE UNIT		538,577		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		1,665,904		35.00
43.00	04300	NURSERY		774,857		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.182028	5,097,825	927,947	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.186656	2,051,750	382,971	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.254250	234,850	59,711	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.151031	36,651	5,535	54.02
57.00	05700	CT SCAN	0.162835	146,776	23,900	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.525785	20,306	10,677	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.133826	1,300,862	174,089	60.00
65.00	06500	RESPIRATORY THERAPY	0.624730	231,550	144,656	65.00
66.00	06600	PHYSICAL THERAPY	0.354129	46,050	16,308	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.275402	7,155	1,971	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150787	47,029	7,091	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.068820	7,198	495	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.060199	2,903,526	174,789	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.223080	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235394	2,205,304	519,115	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.197099	0	0	75.00
76.00	03330	ENDOSCOPY	0.173820	179,825	31,257	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.130068	449,150	58,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.300448	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		14,965,807	2,538,932	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)		14,965,807		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/23/2016 10:54 am
	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)	3,376,405	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9,602,690	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)	270,932	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	148.16	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)	4.22	30.00
31.00	Percentage of Medicaid patient days (see instructions)	11.66	31.00
32.00	Sum of lines 30 and 31	15.88	32.00
33.00	Allowable disproportionate share percentage (see instructions)	3.07	33.00
34.00	Disproportionate share adjustment (see instructions)	99,615	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/23/2016 10:54 am
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	0	35.00
35.01	Factor 3 (see instructions)	0.000068303	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	522,357	442,172	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	131,663	331,025	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	462,688		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	1,284		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)	13,812,330		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)	13,812,330	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,111,700	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	14,924,030	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	14,924,030	61.00
62.00	Deductibles billed to program beneficiaries	1,289,932	62.00
63.00	Coinsurance billed to program beneficiaries	68,187	63.00
64.00	Allowable bad debts (see instructions)	43,832	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	28,491	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	30,024	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	13,594,402	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00		0	70.00
70.01		0	70.01
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	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)	67,371	70.93
70.94	HRR adjustment amount (see instructions)	-7,502	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/23/2016 10:54 am
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13,654,271	71.00
71.01	Sequestration adjustment (see instructions)		273,085	71.01
72.00	Interim payments		13,249,539	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)		131,647	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		8,025	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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/23/2016 10:54 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,376,405	0	3,376,405		3,376,405	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,602,690	0		9,602,690	9,602,690	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	270,932	0	76,848	194,083	270,931	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0307	0.0307	0.0307	0.0307		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	99,615	0	25,914	73,701	99,615	11.00
11.01	Uncompensated care payments	36.00	462,688	0	0	618,301	618,301	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,812,330	0	3,479,167	10,333,163	13,812,330	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,812,330	0	3,479,167	10,333,163	13,812,330	15.00
16.00	Payment for inpatient program capital	50.00	1,111,700	0	287,934	823,766	1,111,700	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/23/2016 10:54 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	3,767,101	11,156,929	14,924,030	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,040,108	0	270,069	770,040	1,040,109	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	37,580	0	9,034	28,546	37,580	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0327	0.0327	0.0327	0.0327		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	34,012	0	8,831	25,181	34,012	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,111,700	0	287,934	823,766	1,111,700	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.054464		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				607,651	607,651	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/23/2016 10:54 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,376,405	3,376,405		3,376,405	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,602,690		9,602,690	9,602,690	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	270,932	76,848	194,083	270,931	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0307	0.0307	0.0307		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	99,615	25,914	73,701	99,615	11.00
11.01	Uncompensated care payments	36.00	462,688	208,366	618,301	826,667	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,812,330	3,687,533	10,124,797	13,812,330	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,812,330	3,687,533	10,124,797	13,812,330	15.00
16.00	Payment for inpatient program capital	50.00	1,111,700	287,934	823,766	1,111,700	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,975,467	10,948,563	14,924,030	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/23/2016 10:54 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,040,108	270,069	770,039	1,040,108	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	37,580	9,034	28,546	37,580	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0327	0.0327	0.0327		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	34,012	8,831	25,181	34,012	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,111,700	287,934	823,766	1,111,700	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	67,371	13,195	54,176	67,371	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-7,502	-2,701	-4,801	-7,502	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/23/2016 10:54 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,497	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,580,872	2.00
3.00	PPS payments	5,538,509	3.00
4.00	Outlier payment (see instructions)	81,686	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,497	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	32,156	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)	32,156	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)	32,156	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	24,659	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)	7,497	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	5,620,195	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	131	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,214,638	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)	4,412,923	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)	4,412,923	30.00
31.00	Primary payer payments	1,015	31.00
32.00	Subtotal (line 30 minus line 31)	4,411,908	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)	113,650	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	73,873	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	106,149	36.00
37.00	Subtotal (see instructions)	4,485,781	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-102	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,485,883	40.00
40.01	Sequestration adjustment (see instructions)	89,718	40.01
41.00	Interim payments	4,317,910	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	78,255	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 11/23/2016 10:54 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,249,539		4,317,910	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)		13,249,539		4,317,910	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		131,647		78,255	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		13,381,186		4,396,165	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/23/2016 10:54 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	6,544	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	4,823	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,181	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	15,858	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	547,800,242	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6,975,596	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)	295,199	8.00
9.00	Sequestration adjustment amount (see instructions)	5,904	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	289,295	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	256,041	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)	33,254	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2016 10:54 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	2,919,872		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)	2,919,872	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)	2,919,872	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	6,336,768		8.00
9.00	Ancillary service charges	14,965,807	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)	21,302,575	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)	21,302,575	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	18,382,703	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)	2,919,872	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)	2,919,872	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)	2,919,872	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)	2,919,872	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,919,872	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)	2,919,872	0	40.00
41.00	Interim payments	2,919,872	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/23/2016 10:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,865,434	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	49,199,911	0	0	0	4.00
5.00	Other receivable	4,038,948	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,155,360	0	0	0	6.00
7.00	Inventory	2,201,516	0	0	0	7.00
8.00	Prepaid expenses	363,615	0	0	0	8.00
9.00	Other current assets	231,273	0	0	0	9.00
10.00	Due from other funds	7,053,262	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	45,798,599	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,111,746	0	0	0	12.00
13.00	Land improvements	2,417,235	0	0	0	13.00
14.00	Accumulated depreciation	-2,137,244	0	0	0	14.00
15.00	Buildings	90,603,932	0	0	0	15.00
16.00	Accumulated depreciation	-44,095,845	0	0	0	16.00
17.00	Leasehold improvements	2,812,309	0	0	0	17.00
18.00	Accumulated depreciation	-1,931,375	0	0	0	18.00
19.00	Fixed equipment	2,818,804	0	0	0	19.00
20.00	Accumulated depreciation	-2,653,049	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	43,704,869	0	0	0	23.00
24.00	Accumulated depreciation	-30,183,228	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	63,468,154	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	589,633,192	208,962	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	30,645,884	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	620,279,076	208,962	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	729,545,829	208,962	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,321,283	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,823,926	0	0	0	38.00
39.00	Payroll taxes payable	278,882	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	2,944,877	0	0	0	43.00
44.00	Other current liabilities	8,802,540	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,171,508	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,209,091	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,209,091	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	40,380,599	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	689,165,230				52.00
53.00	Specific purpose fund		208,962			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)	689,165,230	208,962	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	729,545,829	208,962	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/23/2016 10:54 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		708,487,274		215,135		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		65,945,184				2.00
3.00	Total (sum of line 1 and line 2)		774,432,458		215,135		3.00
4.00		0		0		0	4.00
5.00	OTHER ACTIVITY	0		28,796		0	5.00
6.00	GRANT REVENUE	0		0		0	6.00
7.00	RESTRICTED INCOME	0		0		0	7.00
8.00	ROUNDING	6		0		0	8.00
9.00	OTHER ADJUSTMENT	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		6		28,796		10.00
11.00	Subtotal (line 3 plus line 10)		774,432,464		243,931		11.00
12.00	TRANSFER TO AFFLIATES	85,267,229		0		0	12.00
13.00	NET ASSETS RELEASED FROM RESTRICTION	0		0		0	13.00
14.00	OTHER ADJUSTMENT	0		34,969		0	14.00
15.00	OTHER ADJUSTMENT	0		0		0	15.00
16.00	ROUNDING	5		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		85,267,234		34,969		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		689,165,230		208,962		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 150157 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/23/2016 10:54 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	42,933,746		42,933,746	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	42,933,746		42,933,746	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,079,996		5,079,996	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	11,131,240		11,131,240	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	16,211,236		16,211,236	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	59,144,982		59,144,982	17.00
18.00	Ancillary services	167,548,795	280,102,032	447,650,827	18.00
19.00	Outpatient services	5,746,008	35,258,422	41,004,430	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	0	6,507,282	6,507,282	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	232,439,785	321,867,736	554,307,521	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		133,701,920		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		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)		133,701,920		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/23/2016 10:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	554,307,521	1.00
2.00	Less contractual allowances and discounts on patients' accounts	340,020,974	2.00
3.00	Net patient revenues (line 1 minus line 2)	214,286,547	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	133,701,920	4.00
5.00	Net income from service to patients (line 3 minus line 4)	80,584,627	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,973,497	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	503,183	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	315,587	16.00
17.00	Revenue from sale of drugs to other than patients	10	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	499	21.00
22.00	Rental of hospital space	630,606	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAIN ON INVESTMENTS	-20,393,669	24.00
24.01		0	24.01
24.02	MISCELLANEOUS REVENUE	891,456	24.02
24.03		0	24.03
24.04	INCOME FROM UNCONSOLIDATED ENTITIES	28,368	24.04
24.05	OTHER NONOPERATING	27,742	24.05
24.06	CONSOLIDATING AMT (BILLING ARRANGE)	1,295,420	24.06
24.07	GOVT CLNC INCENTIVE REV	221,601	24.07
24.08	STATE PROGRAM REVENUE	2,203	24.08
24.09	GAIN ON SALE OF PPE	26,372	24.09
25.00	Total other income (sum of lines 6-24)	-13,477,125	25.00
26.00	Total (line 5 plus line 25)	67,107,502	26.00
27.00	LOSS ON UNCONSOLIDATED ENTITIES	839,568	27.00
27.01		0	27.01
27.02		0	27.02
27.03	DONATIONS	322,750	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,162,318	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	65,945,184	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150157	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/23/2016 10:54 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,040,108	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	37,580	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)	48.27	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)	4.22	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	11.66	8.00
9.00	Sum of lines 7 and 8	15.88	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.27	10.00
11.00	Disproportionate share adjustment (see instructions)	34,012	11.00
12.00	Total prospective capital payments (see instructions)	1,111,700	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