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
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0157	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/20/2017 3:53 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/20/2017 Time: 3:53 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT CARMEL HOSPITAL (15-0157) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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	54,726	85,928	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	54,726	85,928	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 12:48 pm

	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)	07/01/2016	06/30/2017	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	305	232	0	0	2,579	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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 12:48 pm

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2017 12:48 pm

		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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 12:48 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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	533,100	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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 12:48 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	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	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)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 12:48 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	170.00
		1.00	2.00	
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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2017 12:48 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	10/09/2017	Y	10/09/2017	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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/20/2017 12:48 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-0157	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/20/2017 12:48 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2017 12:48 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	128	46,720	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		128	46,720	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	15	5,475	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		153	55,845	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2017 12:48 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,905	124	13,175			1.00
2.00	HMO and other (see instructions)	1,407	2,579				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,905	124	13,175			7.00
8.00	INTENSIVE CARE UNIT	304	36	797			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	2,107			12.00
13.00	NURSERY		377	3,270			13.00
14.00	Total (see instructions)	4,209	537	19,349	0.00	578.27	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	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	578.27	27.00
28.00	Observation Bed Days		0	1,756			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			930			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	952			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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2017 12:48 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,169	121	6,631	1.00
2.00	HMO and other (see instructions)			353	686		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	1,169	121	6,631	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	0.00					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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 11/20/2017 12:48 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	43,177,334	0	43,177,334	1,203,100.84	35.89	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		417,751	0	417,751	2,231.02	187.25	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		3,373,536	0	3,373,536	24,062.51	140.20	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		224,467	0	224,467	3,920.00	57.26	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 and/or related organization personnel		4,738,124	0	4,738,124	195,362.62	24.25	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,248,410	0	1,248,410	51,115.23	24.42	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		189,484	0	189,484	1,973.13	96.03	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		1,566,292	0	1,566,292	20,247.28	77.36	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		9,090,021	0	9,090,021	267,058.00	34.04	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
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)		10,911,164	0	10,911,164			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		359,284	0	359,284			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		120,226	0	120,226			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		970,882	0	970,882			23.00
24.00	Wage-related costs (RHC/FQHC)		64,600	0	64,600			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		2,239,174	0	2,239,174			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	350,106	0	350,106	8,110.34	43.17	26.00
27.00	Administrative & General	5.00	6,233,550	0	6,233,550	173,969.53	35.83	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II | Date/Time Prepared: 11/20/2017 12:48 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,740,283	0	1,740,283	11,959.37	145.52	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	192,562	0	192,562	9,876.43	19.50	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)		1,482,778	0	1,482,778	61,368.03	24.16	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		376,956	0	376,956	14,048.08	26.83	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	1,300,689	0	1,300,689	28,425.84	45.76	38.00
39.00	Central Services and Supply	14.00	347,839	0	347,839	14,771.21	23.55	39.00
40.00	Pharmacy	15.00	2,026,929	0	2,026,929	48,611.57	41.70	40.00
41.00	Medical Records & Medical Records Library	16.00	765,674	0	765,674	29,740.32	25.75	41.00
42.00	Social Service	17.00	155,644	0	155,644	4,463.62	34.87	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 11/20/2017 12:49 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		38,441,224	0	38,441,224	1,067,131.19	36.02	1.00
2.00	Excluded area salaries (see instructions)		1,248,410	0	1,248,410	51,115.23	24.42	2.00
3.00	Subtotal salaries (line 1 minus line 2)		37,192,814	0	37,192,814	1,016,015.96	36.61	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,845,797	0	10,845,797	289,278.41	37.49	4.00
5.00	Subtotal wage-related costs (see inst.)		13,270,564	0	13,270,564	0.00	35.68	5.00
6.00	Total (sum of lines 3 thru 5)		61,309,175	0	61,309,175	1,305,294.37	46.97	6.00
7.00	Total overhead cost (see instructions)		14,973,010	0	14,973,010	405,344.34	36.94	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 11/20/2017 12:48 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,738,231	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)	6,498,481	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	72,415	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	41,756	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	161	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	368,194	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	39,836	14.00
15.00	'Workers' Compensation Insurance	235,595	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	170	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,976,069	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	10,854	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	72,247	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	23,678	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,426,156	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 11/20/2017 12:48 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	189,484	12,426,156	1.00
2.00	Hospital	189,484	10,667,969	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	1,758,187	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/20/2017 12:49 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.208548	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,691,484	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	60,650,107	6.00
7.00	Medicaid cost (line 1 times line 6)	12,648,459	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)	7,956,975	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (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
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (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 , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	7,956,975	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,402,829	5,184,791	10,587,620	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,126,749	5,184,791	6,311,540	21.00
22.00	Payments received from patients for amounts previously written off as charity care	89,825	218,828	308,653	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,036,924	4,965,963	6,002,887	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, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,830,713	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	135,482	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	208,434	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	2,622,279	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	619,823	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,622,710	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	14,579,685	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/20/2017 12:48 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		8,314,203	8,314,203	0	8,314,203	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,192,666	4,192,666	0	4,192,666	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	350,106	9,244,159	9,594,265	0	9,594,265	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,233,550	14,840,633	21,074,183	0	21,074,183	5.00
7.00	00700	OPERATION OF PLANT	192,562	5,953,692	6,146,254	0	6,146,254	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	613,071	613,071	0	613,071	8.00
9.00	00900	HOUSEKEEPING	0	1,997,059	1,997,059	0	1,997,059	9.00
10.00	01000	DIETARY	0	2,101,766	2,101,766	-1,528,871	572,895	10.00
11.00	01100	CAFETERIA	0	0	0	1,528,871	1,528,871	11.00
13.00	01300	NURSING ADMINISTRATION	1,300,689	272,451	1,573,140	0	1,573,140	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	347,839	42,280	390,119	0	390,119	14.00
15.00	01500	PHARMACY	2,026,929	628,431	2,655,360	0	2,655,360	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	765,674	456,957	1,222,631	0	1,222,631	16.00
17.00	01700	SOCIAL SERVICE	155,644	138,614	294,258	0	294,258	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,148,255	3,275,049	13,423,304	-1,156,105	12,267,199	30.00
31.00	03100	INTENSIVE CARE UNIT	1,059,956	684,008	1,743,964	0	1,743,964	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,762,909	599,805	3,362,714	0	3,362,714	35.00
43.00	04300	NURSERY	0	0	0	1,156,105	1,156,105	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,766,801	5,811,877	9,578,678	0	9,578,678	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,163,747	1,453,867	3,617,614	0	3,617,614	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,862,453	857,367	2,719,820	0	2,719,820	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	202,590	18,904	221,494	0	221,494	54.02
57.00	05700	CT SCAN	523,323	184,903	708,226	0	708,226	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	398,562	232,295	630,857	0	630,857	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,857,249	2,857,249	0	2,857,249	60.00
65.00	06500	RESPIRATORY THERAPY	959,371	167,760	1,127,131	0	1,127,131	65.00
66.00	06600	PHYSICAL THERAPY	386,589	57,442	444,031	0	444,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,182	1,658	18,840	0	18,840	68.00
69.00	06900	ELECTROCARDIOLOGY	91,668	23,557	115,225	0	115,225	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	95,700	15,716	111,416	0	111,416	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,705,058	4,705,058	0	4,705,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,604,667	5,604,667	0	5,604,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,504,625	3,504,625	0	3,504,625	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,613,659	6,977,987	9,591,646	0	9,591,646	75.00
76.00	03330	ENDOSCOPY	1,592,783	1,423,155	3,015,938	0	3,015,938	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,910,383	816,705	2,727,088	0	2,727,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,928,924	88,069,636	129,998,560	0	129,998,560	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	102,827	399,575	502,402	0	502,402	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	271,235	61,201	332,436	0	332,436	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	492,884	36,125	529,009	0	529,009	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	381,464	312,536	694,000	0	694,000	194.06
200.00		TOTAL (SUM OF LINES 118-199)	43,177,334	88,879,073	132,056,407	0	132,056,407	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/20/2017 12:48 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,361,387	6,952,816		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4,748	4,187,918		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-198,835	9,395,430		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-432,385	20,641,798		5.00
7.00	00700	OPERATION OF PLANT	-86,288	6,059,966		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	613,071		8.00
9.00	00900	HOUSEKEEPING	0	1,997,059		9.00
10.00	01000	DIETARY	-2,005	570,890		10.00
11.00	01100	CAFETERIA	-490,122	1,038,749		11.00
13.00	01300	NURSING ADMINISTRATION	-1,521	1,571,619		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	390,119		14.00
15.00	01500	PHARMACY	-2,962	2,652,398		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-502	1,222,129		16.00
17.00	01700	SOCIAL SERVICE	-21,027	273,231		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,233,228	10,033,971		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,743,964		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-1,419,732	1,942,982		35.00
43.00	04300	NURSERY	0	1,156,105		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-5,692	9,572,986		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,258,071	2,359,543		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,252	2,708,568		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	0	221,494		54.02
57.00	05700	CT SCAN	-23,569	684,657		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	630,857		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	2,857,249		60.00
65.00	06500	RESPIRATORY THERAPY	-76	1,127,055		65.00
66.00	06600	PHYSICAL THERAPY	0	444,031		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	18,840		68.00
69.00	06900	ELECTROCARDIOLOGY	0	115,225		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	111,416		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,705,058		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,604,667		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,504,625		73.00
75.00	07500	ASC (NON-DISTINCT PART)	77,818	9,669,464		75.00
76.00	03330	ENDOSCOPY	13,320	3,029,258		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-54,399	2,672,689		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,516,663	122,481,897		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	502,402		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	332,436		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0		194.00
194.01	07951	MARKETING	709,868	709,868		194.01
194.02	07952	JOINT VENTURES	0	0		194.02
194.04	07954	SCHOOL NURSE	0	529,009		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	694,000		194.06
200.00		TOTAL (SUM OF LINES 118-199)	-6,806,795	125,249,612		200.00

RECLASSIFICATIONS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/20/2017 12:49 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY					
1.00	NURSERY	43.00	973,809	182,296		1.00
	TOTALS		973,809	182,296		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,528,871		1.00
	TOTALS		0	1,528,871		
500.00	Grand Total: Increases		973,809	1,711,167		500.00

RECLASSIFICATIONS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/20/2017 12:49 pm

	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	973,809	182,296	0		1.00
	TOTALS		973,809	182,296			
	C - CAFETERIA						
1.00	DIETARY	10.00	0	1,528,871	0		1.00
	TOTALS		0	1,528,871			
500.00	Grand Total: Decreases		973,809	1,711,167			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2017 12:48 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,111,746	0	0	0	0	1.00
2.00	Land Improvements	2,417,235	13,788	0	13,788	0	2.00
3.00	Buildings and Fixtures	54,822,280	185,176	0	185,176	123,146	3.00
4.00	Building Improvements	38,593,961	17,802,181	0	17,802,181	21,564	4.00
5.00	Fixed Equipment	2,818,804	14,540	0	14,540	588	5.00
6.00	Movable Equipment	43,704,870	2,883,454	0	2,883,454	558,854	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	144,468,896	20,899,139	0	20,899,139	704,152	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	144,468,896	20,899,139	0	20,899,139	704,152	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	2,431,023	1,877,961	2.00
3.00	Buildings and Fixtures	54,884,310	19,321,863	3.00
4.00	Building Improvements	56,374,578	1,281,787	4.00
5.00	Fixed Equipment	2,832,756	927,614	5.00
6.00	Movable Equipment	46,029,470	19,261,371	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	164,663,883	42,670,596	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	164,663,883	42,670,596	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/20/2017 12:48 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,420,816	4,058,808	709,796	64,255	60,528	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,597,245	563,732	0	2,914	28,775	2.00
3.00	Total (sum of lines 1-2)	7,018,061	4,622,540	709,796	67,169	89,303	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	8,314,203		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,192,666		2.00
3.00	Total (sum of lines 1-2)	0	12,506,869		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III | Date/Time Prepared: 11/20/2017 12:48 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	116,522,668	0	116,522,668	0.716833	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,029,469	0	46,029,469	0.283167	0	2.00
3.00	Total (sum of lines 1-2)	162,552,137	0	162,552,137	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	3,420,816	3,417,807	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,597,245	563,732	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,018,061	3,981,539	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	0	64,255	60,528	-10,590	6,952,816	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,914	28,775	-4,748	4,187,918	2.00
3.00	Total (sum of lines 1-2)	0	67,169	89,303	-15,338	11,140,734	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/20/2017 12:49 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-706,014	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	A	-13,573	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,946	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,976,838			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	6,393,263			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-488,747	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-486	PHARMACY	15.00	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	-1,375	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	CAFETERIA REVENUE - IMAGING	B	-490	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00
33.01	CAFETERIA REVENUE - DIETARY	B	-1,219	DIETARY	10.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/20/2017 12:49 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	CAFETERIA REVENUE - FITNESS CENTER	B	-1,284	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	CAFETERIA REVENUE - PHARMACY	B	-995	PHARMACY	15.00	0	33.03
34.00	OTHER MISC REVENUE - BENEFITS	B	-5,975	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
35.00	OTHER MISC REVENUE - ADMIN	B	-197,743	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER MISC REVENUE - MAINT	B	-67,502	OPERATION OF PLANT	7.00	0	36.00
37.00	OTHER MISC REVENUE - OR	B	-5,000	OPERATING ROOM	50.00	0	37.00
38.00	OTHER MISC REVENUE - DIETARY	B	-786	DIETARY	10.00	0	38.00
38.01	OTHER MISC REVENUE - MED RECORDS	B	-502	MEDICAL RECORDS & LIBRARY	16.00	0	38.01
39.00	OTHER MISC REVENUE - ROUTINE	B	-303	ADULTS & PEDIATRICS	30.00	0	39.00
40.00	OTHER MISC REVENUE - NEONATOLOGY	B	-24	NEONATAL INTENSIVE CARE UNIT	35.00	0	40.00
41.00	OTHER MISC REVENUE - RADIOLOGY	B	-600	RADIOLOGY-DIAGNOSTIC	54.00	0	41.00
42.00	OTHER MISC REVENUE - ASC	B	78,019	ASC (NON-DISTINCT PART)	75.00	0	42.00
42.01	OTHER MISC REVENUE - ENDO	B	13,320	ENDOSCOPY	76.00	0	42.01
43.00	PROPERTY RENTAL INCOME	B	-641,001	CAP REL COSTS-BLDG & FIXT	1.00	10	43.00
44.00	PROVIDER ASSESSMENT OFFSET	A	-4,856,155	ADMINISTRATIVE & GENERAL	5.00	0	44.00
44.01	LOSS ON SALE OF PPE	A	-201	ASC (NON-DISTINCT PART)	75.00	0	44.01
45.00	LOBBYING	A	-2,665	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	GAIN ON SALE OF PPE	B	-4,748	CAP REL COSTS-MVBLE EQUIP	2.00	14	46.00
47.00	CONSOLIDATING ENTRY	B	-1,211,223	ADMINISTRATIVE & GENERAL	5.00	0	47.00
49.00	IFUE OPERATING COMFORT IMAGING	B	-8,573	CAP REL COSTS-BLDG & FIXT	1.00	14	49.00
49.01	ENTERTAINMENT EXP - HR	A	-232	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.01
49.02	ENTERTAINMENT EXP - ADMIN	A	-7,531	ADMINISTRATIVE & GENERAL	5.00	0	49.02
49.03	ENTERTAINMENT EXP - NURS ADMIN	A	-1,521	NURSING ADMINISTRATION	13.00	0	49.03
49.04	ENTERTAINMENT EXP - PHARMACY	A	-1,113	PHARMACY	15.00	0	49.04
49.05	ENTERTAINMENT EXP - ROUTINE	A	-735	ADULTS & PEDIATRICS	30.00	0	49.05
49.06	ENTERTAINMENT EXP - OR	A	-692	OPERATING ROOM	50.00	0	49.06
49.07	ENTERTAINMENT EXP - RADIOLOGY	A	-497	RADIOLOGY-DIAGNOSTIC	54.00	0	49.07
49.08	ENTERTAINMENT EXP - RT	A	-76	RESPIRATORY THERAPY	65.00	0	49.08
49.09	ENTERTAINMENT EXP - ED	A	-66	EMERGENCY	91.00	0	49.09
49.10	CORP SPONSORSHIP - ADMIN	A	-501	ADMINISTRATIVE & GENERAL	5.00	0	49.10
49.11	MARKETING - ADMIN	A	-10,393	ADMINISTRATIVE & GENERAL	5.00	0	49.11
49.12	MARKETING - ROUTINE	A	-18,100	ADULTS & PEDIATRICS	30.00	0	49.12
49.13	MARKETING - LABOR & DEL	A	-719	DELIVERY ROOM & LABOR ROOM	52.00	0	49.13
49.14	PROMOTIONAL ITEMS - ADMIN	A	-6,959	ADMINISTRATIVE & GENERAL	5.00	0	49.14
49.15	PROMOTIONAL ITEMS - LABOR & DEL	A	-178	DELIVERY ROOM & LABOR ROOM	52.00	0	49.15
49.16	PROMOTIONAL ITEMS - ED	A	-1,701	EMERGENCY	91.00	0	49.16
49.17	CHARITABLE EXP - ADMIN	A	-1,250	ADMINISTRATIVE & GENERAL	5.00	0	49.17
49.18	CHARITABLE EXP - PHARMACY	A	-368	PHARMACY	15.00	0	49.18
49.19	CHARITABLE EXP - SOC SVC	A	-21,027	SOCIAL SERVICE	17.00	0	49.19
49.20	INCENTIVE PYMT ADJ - SALARY	A	176,022	ADMINISTRATIVE & GENERAL	5.00	0	49.20
49.21	INCENTIVE PYMT ADJ - BENEFITS	A	-23,899	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.21
49.22	TELEPHONE OFFSET - DEPR	A	-2,017	CAP REL COSTS-BLDG & FIXT	1.00	14	49.22
49.23	DONATIONS MADE - A&G	A	-168,876	ADMINISTRATIVE & GENERAL	5.00	0	49.23
49.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.24
49.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.25
49.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.26
49.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.27
49.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.28
49.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.29
49.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.30
49.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.31
49.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.32
49.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.33
49.34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.34

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/20/2017 12:49 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,806,795				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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/20/2017 12:49 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	H.O. COSTS	13,031,914	7,163,452	2.00
3.00	194.01	MARKETING	H.O. COSTS MARKETING	709,868	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	943,605	943,605	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	4,359,709	4,359,709	3.02
3.03	13.00	NURSING ADMINISTRATION	SVH CHARGEBACK	55,193	55,193	3.03
3.04	15.00	PHARMACY	SVH CHARGEBACK	-47,020	-47,020	3.04
3.05	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACK	1,211,762	1,211,762	3.05
3.06	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACK	226,628	226,628	3.06
3.07	31.00	INTENSIVE CARE UNIT	SVH CHARGEBACK	401,496	401,496	3.07
3.08	35.00	NEONATAL INTENSIVE CARE UNIT	SVH CHARGEBACK	50	50	3.08
3.09	50.00	OPERATING ROOM	SVH CHARGEBACK	450	450	3.09
3.10	52.00	DELIVERY ROOM & LABOR ROOM	SVH CHARGEBACK	100	100	3.10
3.11	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	163,229	163,229	3.11
3.12	65.00	RESPIRATORY THERAPY	SVH CHARGEBACK	350	350	3.12
3.13	66.00	PHYSICAL THERAPY	SVH CHARGEBACK	36,050	36,050	3.13
4.00	70.00	ELECTROENCEPHALOGRAPHY	SVH CHARGEBACK	544	544	4.00
4.01	190.00	GIFT, FLOWER, COFFEE SHOP &	SVH CHARGEBACK	22,917	22,917	4.01
4.02	194.04	SCHOOL NURSE	SVH CHARGEBACK	50	50	4.02
4.14	0.00			0	0	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	5,586,425	6,381,379	4.15
4.16	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	706,014	709,796	4.16
4.17	7.00	OPERATION OF PLANT	TRIMEDX	1,899,932	1,913,772	4.17
4.18	4.00	EMPLOYEE BENEFITS DEPARTMENT	PENSION	1,548,796	921,287	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.			30,858,062	24,464,799	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:					
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

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.

(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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/20/2017 12:49 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	5,868,462	0		2.00
3.00	709,868	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
4.14	0	0		4.14
4.15	-794,954	0		4.15
4.16	-3,782	11		4.16
4.17	-13,840	0		4.17
4.18	627,509	0		4.18
4.20	0	0		4.20
5.00	6,393,263			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2017 12:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,524,190	2,214,090	310,100	211,500	8,286	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	1,419,708	1,419,708	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,052,500	0	1,052,500	246,400	10,782	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	1,257,174	1,257,174	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	38,162	0	38,162	271,900	218	6.00
7.00	57.00	CT SCAN	23,569	23,569	0	0	0	7.00
8.00	91.00	EMERGENCY	98,796	0	98,796	211,500	454	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			6,414,099	4,914,541	1,499,558		19,740	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	842,543	42,127	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	1,277,252	63,863	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	28,497	1,425	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	46,164	2,308	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,194,456	109,723	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	842,543	0	2,214,090		2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	1,419,708		3.00
4.00	50.00	OPERATING ROOM	0	1,277,252	0	0		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,257,174		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	28,497	9,665	9,665		6.00
7.00	57.00	CT SCAN	0	0	0	23,569		7.00
8.00	91.00	EMERGENCY	0	46,164	52,632	52,632		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	2,194,456	62,297	4,976,838		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/20/2017 12:49 pm

		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	6,952,816	6,952,816				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,187,918		4,187,918			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,395,430	91,497	0	9,486,927		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,641,798	441,750	534,598	1,380,831	22,998,977	5.00
7.00	00700	OPERATION OF PLANT	6,059,966	812,089	47,193	42,656	6,961,904	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	613,071	37,740	0	0	650,811	8.00
9.00	00900	HOUSEKEEPING	1,997,059	122,901	3,438	0	2,123,398	9.00
10.00	01000	DIETARY	570,890	152,714	3,313	0	726,917	10.00
11.00	01100	CAFETERIA	1,038,749	178,178	8,842	0	1,225,769	11.00
13.00	01300	NURSING ADMINISTRATION	1,571,619	3,203	64,296	288,123	1,927,241	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	390,119	154,888	26,034	77,052	648,093	14.00
15.00	01500	PHARMACY	2,652,398	121,895	288,740	448,997	3,512,030	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,222,129	7,085	0	169,609	1,398,823	16.00
17.00	01700	SOCIAL SERVICE	273,231	16,812	0	34,478	324,521	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,033,971	1,580,357	276,967	2,032,297	13,923,592	30.00
31.00	03100	INTENSIVE CARE UNIT	1,743,964	161,553	84,919	234,797	2,225,233	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,942,982	160,804	27,101	612,029	2,742,916	35.00
43.00	04300	NURSERY	1,156,105	282,115	15,620	215,714	1,669,554	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,572,986	619,928	1,518,956	834,407	12,546,277	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,359,543	329,302	48,746	479,305	3,216,896	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,708,568	333,487	246,691	412,563	3,701,309	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	221,494	8,792	64,557	44,877	339,720	54.02
57.00	05700	CT SCAN	684,657	89,042	118,800	115,924	1,008,423	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	630,857	186,315	78,306	88,288	983,766	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,857,249	112,869	4,981	0	2,975,099	60.00
65.00	06500	RESPIRATORY THERAPY	1,127,055	53,056	65,871	212,516	1,458,498	65.00
66.00	06600	PHYSICAL THERAPY	444,031	45,854	0	85,636	575,521	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,840	1,941	0	3,806	24,587	68.00
69.00	06900	ELECTROCARDIOLOGY	115,225	4,513	15,793	20,306	155,837	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	111,416	4,373	14,843	21,199	151,831	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,705,058	0	0	0	4,705,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,604,667	0	0	0	5,604,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,504,625	0	0	0	3,504,625	73.00
75.00	07500	ASC (NON-DISTINCT PART)	9,669,464	296,425	152,476	578,967	10,697,332	75.00
76.00	03330	ENDOSCOPY	3,029,258	123,018	368,497	352,827	3,873,600	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,672,689	318,358	67,046	423,180	3,481,273	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)	122,481,897	6,852,854	4,146,624	9,210,384	122,064,098	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	502,402	38,675	8,162	22,778	572,017	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	332,436	0	0	60,083	392,519	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	709,868	0	0	0	709,868	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	529,009	20,694	0	109,182	658,885	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	694,000	40,593	33,132	84,500	852,225	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)	125,249,612	6,952,816	4,187,918	9,486,927	125,249,612	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/20/2017 12:49 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,998,977					5.00
7.00	00700	OPERATION OF PLANT	1,565,920	8,527,824				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	146,385	57,395	854,591			8.00
9.00	00900	HOUSEKEEPING	477,610	186,907	0	2,787,915		9.00
10.00	01000	DIETARY	163,503	232,246	0	78,165	1,200,831	10.00
11.00	01100	CAFETERIA	275,709	270,972	0	91,199	0	11.00
13.00	01300	NURSING ADMINISTRATION	433,489	4,872	0	1,640	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	145,774	235,553	24,439	79,278	0	14.00
15.00	01500	PHARMACY	789,950	185,377	0	62,391	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	314,633	10,775	0	3,626	0	16.00
17.00	01700	SOCIAL SERVICE	72,994	25,568	0	8,605	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,131,839	2,403,399	215,638	808,893	1,084,979	30.00
31.00	03100	INTENSIVE CARE UNIT	500,515	245,688	33,282	82,689	41,607	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	616,956	244,550	0	82,306	0	35.00
43.00	04300	NURSERY	375,528	429,039	80,418	144,398	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,821,996	942,783	101,508	317,304	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	723,567	500,800	85,776	168,550	74,245	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	832,524	507,165	18,034	170,692	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	76,412	13,371	1,469	4,500	0	54.02
57.00	05700	CT SCAN	226,822	135,415	4,696	45,575	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	221,276	283,347	67,568	95,364	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	669,180	171,651	0	57,771	0	60.00
65.00	06500	RESPIRATORY THERAPY	328,056	80,687	786	27,156	0	65.00
66.00	06600	PHYSICAL THERAPY	129,450	69,734	1,579	23,470	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,530	2,952	67	993	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,052	6,863	79	2,310	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,151	6,650	78	2,238	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,058,295	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,260,641	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	788,285	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,406,119	450,802	45,947	151,723	0	75.00
76.00	03330	ENDOSCOPY	871,277	187,084	40,777	62,965	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	783,032	484,158	126,453	162,949	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)	22,282,470	8,375,803	848,594	2,736,750	1,200,831	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128,662	58,817	0	19,796	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88,288	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	159,668	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	148,201	31,471	0	10,592	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	191,688	61,733	5,997	20,777	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,998,977	8,527,824	854,591	2,787,915	1,200,831	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/20/2017 12:49 pm

		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	1,863,649					11.00
13.00	01300	NURSING ADMINISTRATION	53,495	2,420,737				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,798	0	1,160,935			14.00
15.00	01500	PHARMACY	91,483	0	5,408	4,646,639		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,968	0	0	0	1,783,825	16.00
17.00	01700	SOCIAL SERVICE	8,401	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	455,394	911,963	19,659	0	184,069	30.00
31.00	03100	INTENSIVE CARE UNIT	51,133	102,399	5,469	0	20,698	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	86,720	173,665	5,968	0	51,179	35.00
43.00	04300	NURSERY	56,086	112,318	2,720	0	7,557	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	207,027	414,589	243,556	0	515,747	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	106,806	213,888	12,507	0	110,834	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	117,965	0	28,550	0	82,699	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	7,279	0	266	0	11,547	54.02
57.00	05700	CT SCAN	26,066	0	4,467	0	31,477	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,809	0	4,788	0	13,868	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	127,633	60.00
65.00	06500	RESPIRATORY THERAPY	55,110	0	4,766	0	13,711	65.00
66.00	06600	PHYSICAL THERAPY	20,648	0	678	0	8,690	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	868	0	0	0	495	68.00
69.00	06900	ELECTROCARDIOLOGY	3,754	0	1,001	0	13,145	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,176	0	463	0	8,230	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	275,433	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	334,025	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,644,850	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	173,736	0	162,393	0	293,734	75.00
76.00	03330	ENDOSCOPY	78,560	157,324	32,782	0	128,778	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	93,454	187,149	15,386	0	159,734	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,806,736	2,273,295	1,160,285	4,644,850	1,783,825	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,409	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,159	0	75	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	78,664	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	34,345	68,778	575	1,789	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)	1,863,649	2,420,737	1,160,935	4,646,639	1,783,825	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/20/2017 12:49 pm

		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	440,089					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	98,779	23,238,204	0	23,238,204		30.00
31.00	03100	INTENSIVE CARE UNIT	45,162	3,353,875	0	3,353,875		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	73,316	4,077,576	0	4,077,576		35.00
43.00	04300	NURSERY	0	2,877,618	0	2,877,618		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,646	18,119,433	0	18,119,433		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,676	5,269,545	0	5,269,545		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,458,938	0	5,458,938		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	454,564	0	454,564		54.02
57.00	05700	CT SCAN	0	1,482,941	0	1,482,941		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,694,786	0	1,694,786		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	4,001,334	0	4,001,334		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,968,770	0	1,968,770		65.00
66.00	06600	PHYSICAL THERAPY	0	829,770	0	829,770		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	35,492	0	35,492		68.00
69.00	06900	ELECTROCARDIOLOGY	0	218,041	0	218,041		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	207,817	0	207,817		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,038,786	0	6,038,786		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,199,333	0	7,199,333		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,937,760	0	8,937,760		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	14,381,786	0	14,381,786		75.00
76.00	03330	ENDOSCOPY	23,056	5,456,203	0	5,456,203		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	112,366	5,605,954	0	5,605,954		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)	417,001	120,908,526	0	120,908,526		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	789,701	0	789,701		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,088	516,129	0	516,129		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	869,536	0	869,536		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	927,813	0	927,813		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	1,237,907	0	1,237,907		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)	440,089	125,249,612	0	125,249,612		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/20/2017 12:48 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	91,497	0	91,497	91,497	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,505,285	441,750	534,598	3,481,633	13,315	5.00
7.00	00700	OPERATION OF PLANT	0	812,089	47,193	859,282	411	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	37,740	0	37,740	0	8.00
9.00	00900	HOUSEKEEPING	0	122,901	3,438	126,339	0	9.00
10.00	01000	DIETARY	0	152,714	3,313	156,027	0	10.00
11.00	01100	CAFETERIA	0	178,178	8,842	187,020	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,203	64,296	67,499	2,778	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	154,888	26,034	180,922	743	14.00
15.00	01500	PHARMACY	0	121,895	288,740	410,635	4,330	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,085	0	7,085	1,635	16.00
17.00	01700	SOCIAL SERVICE	0	16,812	0	16,812	332	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,580,357	276,967	1,857,324	19,614	30.00
31.00	03100	INTENSIVE CARE UNIT	0	161,553	84,919	246,472	2,264	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	160,804	27,101	187,905	5,902	35.00
43.00	04300	NURSERY	0	282,115	15,620	297,735	2,080	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	619,928	1,518,956	2,138,884	8,046	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	329,302	48,746	378,048	4,622	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	333,487	246,691	580,178	3,978	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	8,792	64,557	73,349	433	54.02
57.00	05700	CT SCAN	0	89,042	118,800	207,842	1,118	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	186,315	78,306	264,621	851	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	112,869	4,981	117,850	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	53,056	65,871	118,927	2,049	65.00
66.00	06600	PHYSICAL THERAPY	0	45,854	0	45,854	826	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,941	0	1,941	37	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,513	15,793	20,306	196	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,373	14,843	19,216	204	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	296,425	152,476	448,901	5,583	75.00
76.00	03330	ENDOSCOPY	0	123,018	368,497	491,515	3,402	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	318,358	67,046	385,404	4,081	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)	2,505,285	6,852,854	4,146,624	13,504,763	88,830	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,675	8,162	46,837	220	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	579	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	20,694	0	20,694	1,053	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	40,593	33,132	73,725	815	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)	2,505,285	6,952,816	4,187,918	13,646,019	91,497	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 12:48 pm

		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	3,494,948					5.00
7.00	00700	OPERATION OF PLANT	237,958	1,097,651				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,245	7,388	67,373			8.00
9.00	00900	HOUSEKEEPING	72,578	24,058	0	222,975		9.00
10.00	01000	DIETARY	24,846	29,893	0	6,252	217,018	10.00
11.00	01100	CAFETERIA	41,897	34,878	0	7,294	0	11.00
13.00	01300	NURSING ADMINISTRATION	65,873	627	0	131	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,152	30,319	1,927	6,341	0	14.00
15.00	01500	PHARMACY	120,041	23,861	0	4,990	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,812	1,387	0	290	0	16.00
17.00	01700	SOCIAL SERVICE	11,092	3,291	0	688	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	475,927	309,349	16,999	64,694	196,081	30.00
31.00	03100	INTENSIVE CARE UNIT	76,058	31,624	2,624	6,613	7,519	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	93,753	31,477	0	6,583	0	35.00
43.00	04300	NURSERY	57,065	55,223	6,340	11,549	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	428,832	121,349	8,003	25,378	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109,954	64,460	6,762	13,480	13,418	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	126,511	65,279	1,422	13,652	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	11,612	1,721	116	360	0	54.02
57.00	05700	CT SCAN	34,468	17,430	370	3,645	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	33,625	36,471	5,327	7,627	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	101,689	22,094	0	4,620	0	60.00
65.00	06500	RESPIRATORY THERAPY	49,851	10,386	62	2,172	0	65.00
66.00	06600	PHYSICAL THERAPY	19,671	8,976	125	1,877	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	840	380	5	79	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,327	883	6	185	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,190	856	6	179	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	160,819	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	191,568	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,788	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	365,635	58,025	3,622	12,135	0	75.00
76.00	03330	ENDOSCOPY	132,400	24,080	3,215	5,036	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	118,990	62,318	9,969	13,033	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)	3,386,067	1,078,083	66,900	218,883	217,018	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,552	7,571	0	1,583	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,416	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	24,263	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	22,521	4,051	0	847	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	29,129	7,946	473	1,662	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)	3,494,948	1,097,651	67,373	222,975	217,018	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/20/2017 12:48 pm

		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	271,089					11.00
13.00	01300	NURSING ADMINISTRATION	7,781	144,689				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,043	0	246,447			14.00
15.00	01500	PHARMACY	13,307	0	1,148	578,312		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,141	0	0	0	66,350	16.00
17.00	01700	SOCIAL SERVICE	1,222	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,245	54,510	4,173	0	6,840	30.00
31.00	03100	INTENSIVE CARE UNIT	7,438	6,120	1,161	0	769	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	12,614	10,380	1,267	0	1,902	35.00
43.00	04300	NURSERY	8,158	6,713	577	0	281	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,114	24,780	51,703	0	19,229	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,536	12,784	2,655	0	4,119	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,159	0	6,061	0	3,073	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	1,059	0	57	0	429	54.02
57.00	05700	CT SCAN	3,792	0	948	0	1,170	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,609	0	1,016	0	515	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	4,743	60.00
65.00	06500	RESPIRATORY THERAPY	8,016	0	1,012	0	509	65.00
66.00	06600	PHYSICAL THERAPY	3,004	0	144	0	323	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	126	0	0	0	18	68.00
69.00	06900	ELECTROCARDIOLOGY	546	0	213	0	488	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	607	0	98	0	306	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	58,470	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	70,907	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	578,089	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	25,272	0	34,474	0	10,915	75.00
76.00	03330	ENDOSCOPY	11,427	9,403	6,959	0	4,785	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,594	11,186	3,266	0	5,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	262,810	135,876	246,309	578,089	66,350	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,514	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,769	0	16	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	4,702	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	4,996	4,111	122	223	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)	271,089	144,689	246,447	578,312	66,350	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 12:48 pm

		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	33,437					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,505	3,079,261	0	3,079,261		30.00
31.00	03100	INTENSIVE CARE UNIT	3,431	392,093	0	392,093		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	5,570	357,353	0	357,353		35.00
43.00	04300	NURSERY	0	445,721	0	445,721		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	657	2,856,975	0	2,856,975		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,230	630,068	0	630,068		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	817,313	0	817,313		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	89,136	0	89,136		54.02
57.00	05700	CT SCAN	0	270,783	0	270,783		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	353,662	0	353,662		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	250,996	0	250,996		60.00
65.00	06500	RESPIRATORY THERAPY	0	192,984	0	192,984		65.00
66.00	06600	PHYSICAL THERAPY	0	80,800	0	80,800		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	3,426	0	3,426		68.00
69.00	06900	ELECTROCARDIOLOGY	0	28,150	0	28,150		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	26,662	0	26,662		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	219,289	0	219,289		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	262,475	0	262,475		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	697,877	0	697,877		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	964,562	0	964,562		75.00
76.00	03330	ENDOSCOPY	1,752	693,974	0	693,974		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,538	636,315	0	636,315		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)	31,683	13,349,875	0	13,349,875		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	77,277	0	77,277		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,754	17,534	0	17,534		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	24,263	0	24,263		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	53,868	0	53,868		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	123,202	0	123,202		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)	33,437	13,646,019	0	13,646,019		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 12:48 pm

		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	297,346					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,015,707				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,913	0	42,827,228			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,892	512,615	6,233,550	-22,998,977	102,250,635	5.00
7.00	00700	OPERATION OF PLANT	34,730	45,252	192,562	0	6,961,904	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,614	0	0	0	650,811	8.00
9.00	00900	HOUSEKEEPING	5,256	3,297	0	0	2,123,398	9.00
10.00	01000	DIETARY	6,531	3,177	0	0	726,917	10.00
11.00	01100	CAFETERIA	7,620	8,478	0	0	1,225,769	11.00
13.00	01300	NURSING ADMINISTRATION	137	61,652	1,300,689	0	1,927,241	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	24,963	347,839	0	648,093	14.00
15.00	01500	PHARMACY	5,213	276,867	2,026,929	0	3,512,030	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	765,674	0	1,398,823	16.00
17.00	01700	SOCIAL SERVICE	719	0	155,644	0	324,521	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,586	265,578	9,174,446	0	13,923,592	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	81,427	1,059,956	0	2,225,233	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	25,987	2,762,909	0	2,742,916	35.00
43.00	04300	NURSERY	12,065	14,978	973,809	0	1,669,554	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	1,456,494	3,766,801	0	12,546,277	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	46,742	2,163,747	0	3,216,896	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,262	236,547	1,862,453	0	3,701,309	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	376	61,902	202,590	0	339,720	54.02
57.00	05700	CT SCAN	3,808	113,915	523,323	0	1,008,423	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	75,086	398,562	0	983,766	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	4,776	0	0	2,975,099	60.00
65.00	06500	RESPIRATORY THERAPY	2,269	63,162	959,371	0	1,458,498	65.00
66.00	06600	PHYSICAL THERAPY	1,961	0	386,589	0	575,521	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	83	0	17,182	0	24,587	68.00
69.00	06900	ELECTROCARDIOLOGY	193	15,144	91,668	0	155,837	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	187	14,233	95,700	0	151,831	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,705,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,604,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,504,625	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	146,206	2,613,659	0	10,697,332	75.00
76.00	03330	ENDOSCOPY	5,261	353,344	1,592,783	0	3,873,600	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	64,289	1,910,383	0	3,481,273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	293,071	3,976,111	41,578,818	-22,998,977	99,065,121	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	7,826	102,827	0	572,017	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	271,235	0	392,519	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	709,868	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	492,884	0	658,885	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,736	31,770	381,464	0	852,225	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)	6,952,816	4,187,918	9,486,927		22,998,977	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.382914	1.042884	0.221516		0.224927	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			91,497		3,494,948	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002136		0.034180	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 12:48 pm

		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	239,811					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,614	494,597				8.00
9.00	00900	HOUSEKEEPING	5,256	0	232,941			9.00
10.00	01000	DIETARY	6,531	0	6,531	46,063		10.00
11.00	01100	CAFETERIA	7,620	0	7,620	0	990,298	11.00
13.00	01300	NURSING ADMINISTRATION	137	0	137	0	28,426	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	14,144	6,624	0	14,771	14.00
15.00	01500	PHARMACY	5,213	0	5,213	0	48,612	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	303	0	29,740	16.00
17.00	01700	SOCIAL SERVICE	719	0	719	0	4,464	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,586	124,801	67,586	41,619	241,985	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	19,262	6,909	1,596	27,171	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	0	6,877	0	46,081	35.00
43.00	04300	NURSERY	12,065	46,542	12,065	0	29,803	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	58,748	26,512	0	110,009	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	49,643	14,083	2,848	56,754	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,262	10,437	14,262	0	62,684	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	376	850	376	0	3,868	54.02
57.00	05700	CT SCAN	3,808	2,718	3,808	0	13,851	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	39,105	7,968	0	13,183	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	2,269	455	2,269	0	29,284	65.00
66.00	06600	PHYSICAL THERAPY	1,961	914	1,961	0	10,972	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	83	39	83	0	461	68.00
69.00	06900	ELECTROCARDIOLOGY	193	46	193	0	1,995	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	187	45	187	0	2,219	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	92,319	75.00
76.00	03330	ENDOSCOPY	5,261	23,600	5,261	0	41,745	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	73,185	13,615	0	49,659	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	46,063	960,056	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	1,654	0	5,531	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	6,461	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	1,736	3,471	1,736	0	18,250	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)	8,527,824	854,591	2,787,915	1,200,831	1,863,649	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.560604	1.727853	11.968331	26.069318	1.881907	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,097,651	67,373	222,975	217,018	271,089	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.577150	0.136218	0.957217	4.711330	0.273745	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 12:48 pm

		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	642,330					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,479,230				14.00
15.00	01500	PHARMACY	0	90,746	3,505,975			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	490,945,789		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	241,985	329,849	0	50,665,747	3,119	30.00
31.00	03100	INTENSIVE CARE UNIT	27,171	91,756	0	5,697,110	1,426	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	46,081	100,132	0	14,087,261	2,315	35.00
43.00	04300	NURSERY	29,803	45,643	0	2,080,127	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	110,009	4,086,579	0	141,901,552	273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,754	209,852	0	30,507,609	1,758	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	479,031	0	22,763,217	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	4,469	0	3,178,245	0	54.02
57.00	05700	CT SCAN	0	74,953	0	8,664,315	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	80,342	0	3,817,140	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	35,131,591	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	79,971	0	3,773,987	0	65.00
66.00	06600	PHYSICAL THERAPY	0	11,384	0	2,391,930	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	136,198	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,798	0	3,618,349	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,771	0	2,265,440	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,621,442	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,604,667	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,504,625	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	2,724,756	0	80,851,659	0	75.00
76.00	03330	ENDOSCOPY	41,745	550,035	0	35,446,832	728	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	49,659	258,163	0	43,967,480	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)	603,207	19,468,339	3,504,625	490,945,789	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	1,251	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	20,873	0	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	18,250	9,640	1,350	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)	2,420,737	1,160,935	4,646,639	1,783,825	440,089	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.768681	0.059599	1.325349	0.003633	31.670193	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	144,689	246,447	578,312	66,350	33,437	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.225256	0.012652	0.164950	0.000135	2.406232	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 12:48 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,238,204		23,238,204	0	23,238,204	30.00
31.00	03100	INTENSIVE CARE UNIT	3,353,875		3,353,875	0	3,353,875	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,077,576		4,077,576	0	4,077,576	35.00
43.00	04300	NURSERY	2,877,618		2,877,618	0	2,877,618	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,119,433		18,119,433	0	18,119,433	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,269,545		5,269,545	0	5,269,545	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,458,938		5,458,938	9,665	5,468,603	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	454,564		454,564	0	454,564	54.02
57.00	05700	CT SCAN	1,482,941		1,482,941	0	1,482,941	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,694,786		1,694,786	0	1,694,786	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,001,334		4,001,334	0	4,001,334	60.00
65.00	06500	RESPIRATORY THERAPY	1,968,770	0	1,968,770	0	1,968,770	65.00
66.00	06600	PHYSICAL THERAPY	829,770	0	829,770	0	829,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,492	0	35,492	0	35,492	68.00
69.00	06900	ELECTROCARDIOLOGY	218,041		218,041	0	218,041	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	207,817		207,817	0	207,817	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,038,786		6,038,786	0	6,038,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,199,333		7,199,333	0	7,199,333	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,937,760		8,937,760	0	8,937,760	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,381,786		14,381,786	0	14,381,786	75.00
76.00	03330	ENDOSCOPY	5,456,203		5,456,203	0	5,456,203	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,605,954		5,605,954	52,632	5,658,586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,732,986		2,732,986		2,732,986	92.00
200.00		Subtotal (see instructions)	123,641,512	0	123,641,512	62,297	123,703,809	200.00
201.00		Less Observation Beds	2,732,986		2,732,986		2,732,986	201.00
202.00		Total (see instructions)	120,908,526	0	120,908,526	62,297	120,970,823	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 12:48 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,912,516		42,912,516			30.00
31.00	03100	INTENSIVE CARE UNIT	5,697,110		5,697,110			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	14,087,261		14,087,261			35.00
43.00	04300	NURSERY	2,080,127		2,080,127			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,693,172	84,208,380	141,901,552	0.127690	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,759,645	747,964	30,507,609	0.172729	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,211,033	20,552,184	22,763,217	0.239814	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	436,171	2,742,074	3,178,245	0.143024	0.000000	54.02
57.00	05700	CT SCAN	1,420,205	7,244,110	8,664,315	0.171155	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	204,547	3,612,593	3,817,140	0.443994	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	14,340,910	20,790,681	35,131,591	0.113896	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,744,185	1,029,802	3,773,987	0.521668	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,249,406	1,142,524	2,391,930	0.346904	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	98,116	38,082	136,198	0.260591	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	987,171	2,631,178	3,618,349	0.060260	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,715,438	550,002	2,265,440	0.091734	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,874,360	24,613,103	39,487,463	0.152929	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,598,788	4,511,653	21,110,441	0.341032	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,333,542	10,886,581	28,220,123	0.316716	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,233,494	79,618,165	80,851,659	0.177879	0.000000	75.00
76.00	03330	ENDOSCOPY	2,076,480	33,370,352	35,446,832	0.153926	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,282,099	37,685,381	43,967,480	0.127502	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	972,704	6,780,527	7,753,231	0.352496	0.000000	92.00
200.00		Subtotal (see instructions)	237,008,480	342,755,336	579,763,816			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	237,008,480	342,755,336	579,763,816			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 12:48 pm

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	0.127690	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.172729	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240239	54.00
54.01	03480	ONCOLOGY	0.000000	54.01
54.02	05402	ULTRASOUND	0.143024	54.02
57.00	05700	CT SCAN	0.171155	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.443994	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.113896	60.00
65.00	06500	RESPIRATORY THERAPY	0.521668	65.00
66.00	06600	PHYSICAL THERAPY	0.346904	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.260591	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060260	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.091734	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152929	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.341032	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316716	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.177879	75.00
76.00	03330	ENDOSCOPY	0.153926	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.128699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.352496	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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 12:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,238,204		23,238,204	0	23,238,204	30.00
31.00	03100	INTENSIVE CARE UNIT	3,353,875		3,353,875	0	3,353,875	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,077,576		4,077,576	0	4,077,576	35.00
43.00	04300	NURSERY	2,877,618		2,877,618	0	2,877,618	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,119,433		18,119,433	0	18,119,433	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,269,545		5,269,545	0	5,269,545	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,458,938		5,458,938	9,665	5,468,603	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	454,564		454,564	0	454,564	54.02
57.00	05700	CT SCAN	1,482,941		1,482,941	0	1,482,941	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,694,786		1,694,786	0	1,694,786	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,001,334		4,001,334	0	4,001,334	60.00
65.00	06500	RESPIRATORY THERAPY	1,968,770	0	1,968,770	0	1,968,770	65.00
66.00	06600	PHYSICAL THERAPY	829,770	0	829,770	0	829,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,492	0	35,492	0	35,492	68.00
69.00	06900	ELECTROCARDIOLOGY	218,041		218,041	0	218,041	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	207,817		207,817	0	207,817	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,038,786		6,038,786	0	6,038,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,199,333		7,199,333	0	7,199,333	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,937,760		8,937,760	0	8,937,760	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,381,786		14,381,786	0	14,381,786	75.00
76.00	03330	ENDOSCOPY	5,456,203		5,456,203	0	5,456,203	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,605,954		5,605,954	52,632	5,658,586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,732,986		2,732,986		2,732,986	92.00
200.00		Subtotal (see instructions)	123,641,512	0	123,641,512	62,297	123,703,809	200.00
201.00		Less Observation Beds	2,732,986		2,732,986		2,732,986	201.00
202.00		Total (see instructions)	120,908,526	0	120,908,526	62,297	120,970,823	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 12:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,912,516		42,912,516			30.00
31.00	03100	INTENSIVE CARE UNIT	5,697,110		5,697,110			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	14,087,261		14,087,261			35.00
43.00	04300	NURSERY	2,080,127		2,080,127			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,693,172	84,208,380	141,901,552	0.127690	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,759,645	747,964	30,507,609	0.172729	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,211,033	20,552,184	22,763,217	0.239814	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	436,171	2,742,074	3,178,245	0.143024	0.000000	54.02
57.00	05700	CT SCAN	1,420,205	7,244,110	8,664,315	0.171155	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	204,547	3,612,593	3,817,140	0.443994	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	14,340,910	20,790,681	35,131,591	0.113896	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,744,185	1,029,802	3,773,987	0.521668	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,249,406	1,142,524	2,391,930	0.346904	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	98,116	38,082	136,198	0.260591	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	987,171	2,631,178	3,618,349	0.060260	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,715,438	550,002	2,265,440	0.091734	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,874,360	24,613,103	39,487,463	0.152929	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,598,788	4,511,653	21,110,441	0.341032	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,333,542	10,886,581	28,220,123	0.316716	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,233,494	79,618,165	80,851,659	0.177879	0.000000	75.00
76.00	03330	ENDOSCOPY	2,076,480	33,370,352	35,446,832	0.153926	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,282,099	37,685,381	43,967,480	0.127502	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	972,704	6,780,527	7,753,231	0.352496	0.000000	92.00
200.00		Subtotal (see instructions)	237,008,480	342,755,336	579,763,816			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	237,008,480	342,755,336	579,763,816			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 12:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part I Date/Time Prepared: 11/20/2017 12:49 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,079,261	0	3,079,261	14,931	206.23	30.00
31.00	INTENSIVE CARE UNIT	392,093		392,093	797	491.96	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	357,353		357,353	2,107	169.60	35.00
43.00	NURSERY	445,721		445,721	3,270	136.31	43.00
200.00	Total (lines 30-199)	4,274,428		4,274,428	21,105		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,905	805,328				30.00
31.00	INTENSIVE CARE UNIT	304	149,556				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)	4,209	954,884				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/20/2017 12:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,856,975	141,901,552	0.020134	17,046,246	343,209	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	630,068	30,507,609	0.020653	22,437	463	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	817,313	22,763,217	0.035905	540,312	19,400	54.00
54.01	03480	ONCOLOGY	0	0	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	89,136	3,178,245	0.028046	149,000	4,179	54.02
57.00	05700	CT SCAN	270,783	8,664,315	0.031253	564,400	17,639	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	353,662	3,817,140	0.092651	54,786	5,076	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	250,996	35,131,591	0.007144	4,245,315	30,329	60.00
65.00	06500	RESPIRATORY THERAPY	192,984	3,773,987	0.051135	1,009,045	51,598	65.00
66.00	06600	PHYSICAL THERAPY	80,800	2,391,930	0.033780	562,452	19,000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,426	136,198	0.025155	54,011	1,359	68.00
69.00	06900	ELECTROCARDIOLOGY	28,150	3,618,349	0.007780	459,548	3,575	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,662	2,265,440	0.011769	783,235	9,218	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	219,289	39,487,463	0.005553	3,319,287	18,432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	262,475	21,110,441	0.012433	6,023,371	74,889	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	697,877	28,220,123	0.024730	4,497,595	111,226	73.00
75.00	07500	ASC (NON-DISTINCT PART)	964,562	80,851,659	0.011930	0	0	75.00
76.00	03330	ENDOSCOPY	693,974	35,446,832	0.019578	430,699	8,432	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	636,315	43,967,480	0.014472	2,627,486	38,025	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	362,145	7,753,231	0.046709	365,716	17,082	92.00
200.00		Total (lines 50-199)	9,437,592	514,986,802		42,754,941	773,131	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part III Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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	14,931	0.00	3,905	0		30.00
31.00	03100	INTENSIVE CARE UNIT	797	0.00	304	0		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,107	0.00	0	0		35.00
43.00	04300	NURSERY	3,270	0.00	0	0		43.00
200.00		Total (lines 30-199)	21,105		4,209	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	141,901,552	0.000000	0.000000	17,046,246	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	30,507,609	0.000000	0.000000	22,437	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,763,217	0.000000	0.000000	540,312	54.00
54.01	03480	ONCOLOGY	0	0	0.000000	0.000000	0	54.01
54.02	05402	ULTRASOUND	0	3,178,245	0.000000	0.000000	149,000	54.02
57.00	05700	CT SCAN	0	8,664,315	0.000000	0.000000	564,400	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,817,140	0.000000	0.000000	54,786	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	35,131,591	0.000000	0.000000	4,245,315	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,773,987	0.000000	0.000000	1,009,045	65.00
66.00	06600	PHYSICAL THERAPY	0	2,391,930	0.000000	0.000000	562,452	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	136,198	0.000000	0.000000	54,011	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,618,349	0.000000	0.000000	459,548	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,265,440	0.000000	0.000000	783,235	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,487,463	0.000000	0.000000	3,319,287	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,110,441	0.000000	0.000000	6,023,371	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,220,123	0.000000	0.000000	4,497,595	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	80,851,659	0.000000	0.000000	0	75.00
76.00	03330	ENDOSCOPY	0	35,446,832	0.000000	0.000000	430,699	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	43,967,480	0.000000	0.000000	2,627,486	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,753,231	0.000000	0.000000	365,716	92.00
200.00		Total (lines 50-199)	0	514,986,802			42,754,941	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	10,469,468	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,813	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,469,024	0		54.00
54.01	03480	ONCOLOGY	0	0	0		54.01
54.02	05402	ULTRASOUND	0	692,385	0		54.02
57.00	05700	CT SCAN	0	1,909,907	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	834,650	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	4,673,101	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	320,838	0		65.00
66.00	06600	PHYSICAL THERAPY	0	48,794	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	715,846	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	93,884	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,609,018	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	485,187	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,020,968	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03330	ENDOSCOPY	0	3,909,915	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	7,430,298	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,997,918	0		92.00
200.00		Total (lines 50-199)	0	38,686,014	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.127690	10,469,468	0	0	1,336,846	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.172729	4,813	0	0	831	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239814	1,469,024	0	0	352,293	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.143024	692,385	0	0	99,028	54.02
57.00	05700	CT SCAN	0.171155	1,909,907	0	0	326,890	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.443994	834,650	0	0	370,580	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.113896	4,673,101	0	0	532,248	60.00
65.00	06500	RESPIRATORY THERAPY	0.521668	320,838	0	0	167,371	65.00
66.00	06600	PHYSICAL THERAPY	0.346904	48,794	0	0	16,927	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.260591	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060260	715,846	0	0	43,137	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.091734	93,884	0	0	8,612	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152929	1,609,018	0	0	246,066	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.341032	485,187	0	0	165,464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316716	2,020,968	0	10,807	640,073	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.177879	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.153926	3,909,915	0	0	601,838	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.127502	7,430,298	0	0	947,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.352496	1,997,918	0	0	704,258	92.00
200.00		Subtotal (see instructions)		38,686,014	0	10,807	6,559,840	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		38,686,014	0	10,807	6,559,840	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	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	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,423		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03330	ENDOSCOPY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	3,423		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	3,423		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 12:49 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.127690	0	7,160,922	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.172729	0	100,085	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239814	0	1,320,041	0	0	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.143024	0	263,128	0	0	54.02
57.00	05700	CT SCAN	0.171155	0	547,680	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.443994	0	270,238	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.113896	0	2,675,425	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.521668	0	231,810	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.346904	0	72,470	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.260591	0	526	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060260	0	68,836	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.091734	0	92,439	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152929	0	1,802,730	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.341032	0	428,283	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316716	0	1,124,355	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.177879	0	7,885,694	0	0	75.00
76.00	03330	ENDOSCOPY	0.153926	0	2,355,230	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.127502	0	5,116,969	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.352496	0	833,429	0	0	92.00
200.00		Subtotal (see instructions)		0	32,350,290	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	32,350,290	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 12:49 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	914,378	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,288	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	316,564	0		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	37,634	0		54.02
57.00	05700	CT SCAN	93,738	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	119,984	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	304,720	0		60.00
65.00	06500	RESPIRATORY THERAPY	120,928	0		65.00
66.00	06600	PHYSICAL THERAPY	25,140	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	137	0		68.00
69.00	06900	ELECTROCARDIOLOGY	4,148	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,480	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	275,690	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	146,058	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356,101	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,402,699	0		75.00
76.00	03330	ENDOSCOPY	362,531	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	652,424	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	293,780	0		92.00
200.00		Subtotal (see instructions)	5,452,422	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,452,422	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,931	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,931	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)	13,175	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,905	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)	23,238,204	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)	23,238,204	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)	23,238,204	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)	1,556.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,077,625	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)	6,077,625	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,353,875	797	4,208.12	304	1,279,268	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	4,077,576	2,107	1,935.25	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,290,795	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	15,647,688	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)	954,884	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	773,131	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,728,015	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,919,673	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)	1,756	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,556.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,732,986	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,079,261	23,238,204	0.132509	2,732,986	362,145	90.00
91.00	Nursing School cost	0	23,238,204	0.000000	2,732,986	0	91.00
92.00	Allied health cost	0	23,238,204	0.000000	2,732,986	0	92.00
93.00	All other Medical Education	0	23,238,204	0.000000	2,732,986	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 12:49 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,931	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,931	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)	13,175	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)	124	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)	3,270	15.00
16.00	Nursery days (title V or XIX only)	377	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)	23,238,204	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)	23,238,204	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)	23,238,204	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)	1,556.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	192,990	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)	192,990	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 12:49 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,877,618	3,270	880.01	377	331,764	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,353,875	797	4,208.12	36	151,492	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	4,077,576	2,107	1,935.25	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,640,448	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,316,694	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)	1,756	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,556.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,732,986	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 12:49 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,079,261	23,238,204	0.132509	2,732,986	362,145	90.00
91.00	Nursing School cost	0	23,238,204	0.000000	2,732,986	0	91.00
92.00	Allied health cost	0	23,238,204	0.000000	2,732,986	0	92.00
93.00	All other Medical Education	0	23,238,204	0.000000	2,732,986	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,906,882		30.00
31.00	03100	INTENSIVE CARE UNIT		3,597,061		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	0.127690	17,046,246	2,176,635	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.172729	22,437	3,876	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240239	540,312	129,804	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.143024	149,000	21,311	54.02
57.00	05700	CT SCAN	0.171155	564,400	96,600	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.443994	54,786	24,325	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.113896	4,245,315	483,524	60.00
65.00	06500	RESPIRATORY THERAPY	0.521668	1,009,045	526,386	65.00
66.00	06600	PHYSICAL THERAPY	0.346904	562,452	195,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.260591	54,011	14,075	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060260	459,548	27,692	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.091734	783,235	71,849	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152929	3,319,287	507,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.341032	6,023,371	2,054,162	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316716	4,497,595	1,424,460	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.177879	0	0	75.00
76.00	03330	ENDOSCOPY	0.153926	430,699	66,296	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.128699	2,627,486	338,155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.352496	365,716	128,913	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		42,754,941	8,290,795	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)		42,754,941		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/20/2017 12:49 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,952,842		30.00
31.00	03100	INTENSIVE CARE UNIT		953,013		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		2,741,221		35.00
43.00	04300	NURSERY		354,971		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.127690	7,083,406	904,480	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.172729	2,670,726	461,312	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239814	242,601	58,179	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.143024	51,005	7,295	54.02
57.00	05700	CT SCAN	0.171155	149,566	25,599	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.443994	23,484	10,427	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.113896	1,672,368	190,476	60.00
65.00	06500	RESPIRATORY THERAPY	0.521668	395,891	206,524	65.00
66.00	06600	PHYSICAL THERAPY	0.346904	100,790	34,964	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.260591	5,621	1,465	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060260	54,418	3,279	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.091734	17,202	1,578	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.152929	1,945,745	297,561	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.341032	1,575,693	537,362	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316716	2,501,477	792,258	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.177879	0	0	75.00
76.00	03330	ENDOSCOPY	0.153926	177,736	27,358	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.127502	630,038	80,331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.352496	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,297,767	3,640,448	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)		19,297,767		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/20/2017 12:48 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,875,482	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	8,403,043	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)	134,470	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)	148.19	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)	2.29	30.00
31.00	Percentage of Medicaid patient days (see instructions)	14.68	31.00
32.00	Sum of lines 30 and 31	16.97	32.00
33.00	Allowable disproportionate share percentage (see instructions)	3.78	33.00
34.00	Disproportionate share adjustment (see instructions)	106,582	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A | Date/Time Prepared: 11/20/2017 12:48 pm

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000069023	0.000062111	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	442,172	371,269	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	111,147	277,689	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	388,836		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)	1,480		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	11,908,413		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)		11,908,413	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		967,053	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
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		12,875,466	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,875,466	61.00
62.00	Deductibles billed to program beneficiaries		1,203,272	62.00
63.00	Coinsurance billed to program beneficiaries		18,473	63.00
64.00	Allowable bad debts (see instructions)		77,826	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		50,587	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		20,556	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,704,308	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)		40,445	70.93
70.94	HRR adjustment amount (see instructions)		-1,438	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/20/2017 12:48 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,743,315	71.00
71.01	Sequestration adjustment (see instructions)		234,866	71.01
72.00	Interim payments		11,453,723	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)		54,726	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		7,081,658	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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/20/2017 12:48 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,875,482	0	2,875,482		2,875,482	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,403,043	0		8,403,043	8,403,043	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	134,470	0	45,610	88,859	134,469	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	0.0378	0.0378	0.0378	0.0378		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	106,582	0	27,173	79,409	106,582	11.00
11.01	Uncompensated care payments	36.00	388,836	0	0	618,301	618,301	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,908,413	0	2,948,265	8,960,148	11,908,413	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,908,413	0	2,948,265	8,960,148	11,908,413	15.00
16.00	Payment for inpatient program capital	50.00	967,053	0	246,433	720,620	967,053	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							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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/20/2017 12:48 pm

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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	3,194,698	9,680,768	12,875,466	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	911,107	0	230,583	680,524	911,107	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	24,057	0	7,780	16,277	24,057	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	0.0350	0.0350	0.0350	0.0350		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	31,889	0	8,070	23,819	31,889	25.00
26.00	Total prospective capital payments (see instructions)	12.00	967,053	0	246,433	720,620	967,053	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				0.054464	0.019643		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			173,996		173,996	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				190,159	190,159	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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2017 12:49 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,875,482	2,875,482		2,875,482	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,403,043		8,403,043	8,403,043	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	134,470	45,610	88,859	134,469	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	0.0378	0.0378	0.0378		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	106,582	27,173	79,409	106,582	11.00
11.01	Uncompensated care payments	36.00	388,836	111,147	277,689	388,836	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,908,413	3,059,412	8,849,001	11,908,413	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,908,413	3,059,412	8,849,001	11,908,413	15.00
16.00	Payment for inpatient program capital	50.00	967,053	246,433	720,620	967,053	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						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			3,305,845	9,569,621	12,875,466	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2017 12:49 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	911,107	230,583	680,524	911,107	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	24,057	7,780	16,277	24,057	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	0.0350	0.0350	0.0350		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	31,889	8,070	23,819	31,889	25.00
26.00	Total prospective capital payments (see instructions)	12.00	967,053	246,433	720,620	967,053	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	40,445	16,223	24,222	40,445	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	-1,438	-1,438	0	-1,438	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: 15-0157	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/20/2017 12:48 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,423	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,559,840	2.00
3.00	PPS payments	5,505,719	3.00
4.00	Outlier payment (see instructions)	87,906	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)	3,423	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	10,807	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)	10,807	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)	10,807	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,384	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)	3,423	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)	5,593,625	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,149,442	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)	4,447,606	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)	4,447,606	30.00
31.00	Primary payer payments	996	31.00
32.00	Subtotal (line 30 minus line 31)	4,446,610	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)	130,608	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	84,895	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	82,102	36.00
37.00	Subtotal (see instructions)	4,531,505	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,531,505	40.00
40.01	Sequestration adjustment (see instructions)	90,630	40.01
41.00	Interim payments	4,354,947	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	85,928	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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2017 12:48 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,453,723		4,354,947	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)		11,453,723		4,354,947	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		54,726		85,928	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,508,449		4,440,875	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: 15-0157	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/20/2017 12:49 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	6,631	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	4,209	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,407	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	16,079	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	579,763,816	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	10,587,620	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-3 Part VII | Date/Time Prepared: 11/20/2017 12:48 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	4,316,694		1.00
2.00	Medical and other services		5,452,422	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,316,694	5,452,422	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)	4,316,694	5,452,422	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	19,297,767	32,350,290	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)	25,634,535	32,350,290	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)	25,634,535	32,350,290	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	21,317,841	26,897,868	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)	4,316,694	5,452,422	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)	4,316,694	5,452,422	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)	4,316,694	5,452,422	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)	4,316,694	5,452,422	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	4,316,694	5,452,422	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)	4,316,694	5,452,422	40.00
41.00	Interim payments	4,316,694	5,452,422	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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/20/2017 12:48 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	8,060,729	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	48,282,894	0	0	0	4.00
5.00	Other receivable	4,058,981	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-20,595,159	0	0	0	6.00
7.00	Inventory	2,404,078	0	0	0	7.00
8.00	Prepaid expenses	346,175	0	0	0	8.00
9.00	Other current assets	154,322	0	0	0	9.00
10.00	Due from other funds	8,860,303	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	51,572,323	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,111,746	0	0	0	12.00
13.00	Land improvements	2,431,024	0	0	0	13.00
14.00	Accumulated depreciation	-2,167,886	0	0	0	14.00
15.00	Buildings	95,962,891	0	0	0	15.00
16.00	Accumulated depreciation	-45,373,422	0	0	0	16.00
17.00	Leasehold improvements	2,795,304	0	0	0	17.00
18.00	Accumulated depreciation	-2,173,252	0	0	0	18.00
19.00	Fixed equipment	15,333,450	0	0	0	19.00
20.00	Accumulated depreciation	-4,537,872	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	46,029,469	0	0	0	23.00
24.00	Accumulated depreciation	-33,383,400	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)	77,028,052	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	227,015	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	24,642,744	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,642,744	227,015	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	153,243,119	227,015	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,417,977	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,736,115	0	0	0	38.00
39.00	Payroll taxes payable	190,987	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	25,629,587	0	0	0	43.00
44.00	Other current liabilities	7,502,680	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	43,477,346	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	19,940,261	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,940,261	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	63,417,607	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	89,825,512				52.00
53.00	Specific purpose fund		227,015			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)	89,825,512	227,015	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	153,243,119	227,015	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/20/2017 12:48 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		689,154,095		208,962		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		85,983,071				2.00
3.00	Total (sum of line 1 and line 2)		775,137,166		208,962		3.00
4.00		0		0		0	4.00
5.00	OTHER ACTIVITY	0		22,809		0	5.00
6.00	GRANT REVENUE	0		0		0	6.00
7.00	RESTRICTED INCOME	0		0		0	7.00
8.00	ROUNDING	0		0		0	8.00
9.00	OTHER ADJUSTMENT	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		22,809		10.00
11.00	Subtotal (line 3 plus line 10)		775,137,166		231,771		11.00
12.00	TRANSFER TO AFFLIATES	59,102,830		0		0	12.00
13.00	OTHER ADJUSTMENT	0		0		0	13.00
14.00	DISTRIBUTIONS	10,000,126		4,756		0	14.00
15.00	NET ASSET TRANSFER TO FROM ALPHA	614,997,470		0		0	15.00
16.00	CONSOLIDATION	1,211,223		0		0	16.00
17.00	ROUNDING	5		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		685,311,654		4,756		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		89,825,512		227,015		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	OTHER ADJUSTMENT		0			13.00
14.00	DISTRIBUTIONS		0			14.00
15.00	NET ASSET TRANSFER TO FROM ALPHA		0			15.00
16.00	CONSOLIDATION		0			16.00
17.00	ROUNDING		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: 15-0157 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/20/2017 12:48 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	44,992,643		44,992,643	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)	44,992,643		44,992,643	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,697,110		5,697,110	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	14,087,261		14,087,261	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	19,784,371		19,784,371	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	64,777,014		64,777,014	17.00
18.00	Ancillary services	164,976,664	298,289,428	463,266,092	18.00
19.00	Outpatient services	7,254,803	44,465,908	51,720,711	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	5,779,993	5,779,993	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	237,008,481	348,535,329	585,543,810	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		132,056,407		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	CONSOLIDATING EXPENSE	1,211,223			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)		1,211,223		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		130,845,184		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0157	Period: From 07/01/2016 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/20/2017 12:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	585,543,810	1.00
2.00	Less contractual allowances and discounts on patients' accounts	366,621,162	2.00
3.00	Net patient revenues (line 1 minus line 2)	218,922,648	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	130,845,184	4.00
5.00	Net income from service to patients (line 3 minus line 4)	88,077,464	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	492,735	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	290,499	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	486	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	1,375	21.00
22.00	Rental of hospital space	641,001	22.00
23.00	Governmental appropriations	0	23.00
24.00		0	24.00
24.01	CONTRACT SERVICE REVENUE	694,506	24.01
24.02	OTHER MISCELLANEOUS RVENUE	326,195	24.02
24.03		0	24.03
24.04	INCOME FROM UNCONSOLIDATED ENTITIES	8,573	24.04
24.05	OTHER NONOPERATING	11,135	24.05
24.06	CONSOLIDATING AMT (BILLING ARRANGE)	1,211,223	24.06
24.07	GOVT CLNC INCENTIVE REV	33,254	24.07
24.08	STATE PROGRAM REVENUE	0	24.08
24.09	GAIN ON SALE OF PPE	4,748	24.09
25.00	Total other income (sum of lines 6-24)	3,715,730	25.00
26.00	Total (line 5 plus line 25)	91,793,194	26.00
27.00	LOSS ON UNCONSOLIDATED ENTITIES	5,641,247	27.00
27.01		0	27.01
27.02		0	27.02
27.03	DONATIONS	168,876	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	5,810,123	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	85,983,071	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0157	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/20/2017 12:49 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	911,107	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	24,057	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)	49.21	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)	2.29	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	14.68	8.00
9.00	Sum of lines 7 and 8	16.97	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.50	10.00
11.00	Disproportionate share adjustment (see instructions)	31,889	11.00
12.00	Total prospective capital payments (see instructions)	967,053	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