

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/28/2016 2:12 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/28/2016	Time: 2:12 pm
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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. ALEXIUS MEDICAL CENTER (140290) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	390,809	13,167	144,831	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	390,809	13,167	144,831	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: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 2:11 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1555 BARRINGTON ROAD			PO Box:						1.00		
2.00	City: HOFFMAN ESTATES			State: IL		Zip Code: 60194		County: COOK		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				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. ALEXIUS MEDICAL CENTER		140290	16974	1	09/16/1979	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:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2015	06/30/2016		20.00		
21.00	Type of Control (see instructions)						1			21.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							1	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.			5,797	1,080	43	0	14,567	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	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 2:11 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	XVII	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.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							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				
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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					
64.00	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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))				
		1.00	2.00	3.00	4.00	5.00				
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				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.			N		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	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 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00	
				1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00	
				1.00	2.00	
				3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	471,566	0	0	118.01	
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			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: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 2:11 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	149019				140.00
		1.00	2.00			3.00	
141.00	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.						
	Name: ALEXIAN BROTHERS HOSPITAL NETWORK	Contractor's Name: WPS		Contractor's Number: 05901			141.00
142.00	Street: 3040 SALT CREEK LANE	PO Box:					142.00
143.00	City: ARLINGTON HEIGHTS, IL	State: IL		Zip Code: 60005			143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y				144.00
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y					145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00
						1.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
155.00	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)	N	N	N	N		155.00
156.00	Hospital	N	N	N	N		156.00
157.00	Subprovider - IPF	N	N	N	N		157.00
158.00	Subprovider - IRF	N	N	N	N		158.00
159.00	SUBPROVIDER	N	N	N	N		159.00
160.00	SNF	N	N	N	N		160.00
161.00	HOME HEALTH AGENCY	N	N	N	N		161.00
161.00	CMHC	N	N	N	N		161.00
						1.00	
165.00	Multi campus Is this hospital part of a Multi campus 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
							1.00
167.00	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 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)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 2:11 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)		10/01/2014	09/30/2015	170.00
				1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part II Date/Time Prepared: 11/28/2016 2:11 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				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				N		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/03/2016	Y	11/03/2016		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/28/2016 2:11 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 relieved 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?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	TONY		LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	LEONE CONSULTING			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	8472751023		TONY@LEONE-CONSULTING.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/28/2016 2:11 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.	CONSULTANT		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: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2016 2:11 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	260	88,938	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)		260	88,938	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	35	12,810	0.00	0	8.00
8.01 NEONATAL NICU	31.01	16	5,856	0.00	0	8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		311	107,604	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		311				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: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2016 2:11 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	24,318	3,332	63,669			1.00
2.00 HMO and other (see instructions)	5,682	15,690				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	24,318	3,332	63,669			7.00
8.00 INTENSIVE CARE UNIT	2,157	263	5,195			8.00
8.01 NEONATAL NICU	0	1,463	7,780			8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		739	7,210			13.00
14.00 Total (see instructions)	26,475	5,797	83,854	0.00	1,620.12	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	1,620.12	27.00
28.00 Observation Bed Days		0	8,467			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2016 2:11 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	4,982	1,095	17,420	1.00
2.00 HMO and other (see instructions)			1,087	2,868		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
8.01 NEONATAL NICU						8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	4,982	1,095	17,420	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet S-3 Part II Date/Time Prepared: 11/28/2016 2:11 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	98,577,622	0	98,577,622	2,933,536.00	33.60	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		1,179,471	0	1,179,471	8,690.00	135.73	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		135,897	0	135,897	5,567.00	24.41	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		1,911,159	0	1,911,159	34,631.00	55.19	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		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		38,649,223	0	38,649,223	586,059.00	65.95	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		19,520,848	0	19,520,848			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		26,948	0	26,948			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	129,867	0	129,867	4,187.00	31.02	26.00
27.00	Administrative & General	5.00	8,237,238	0	8,237,238	303,505.00	27.14	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	747,172	0	747,172	24,623.00	30.34	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,264	0	1,264	48.00	26.33	32.00
33.00	Housekeeping under contract (see instructions)		3,779,118	0	3,779,118	164,579.00	22.96	33.00
34.00	Dietary	10.00	68,011	-26,562	41,449	946.00	43.82	34.00
35.00	Dietary under contract (see instructions)		3,881,688	0	3,881,688	152,838.00	25.40	35.00
36.00	Cafeteria	11.00	0	26,562	26,562	606.00	43.83	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,782,074	0	1,782,074	35,993.00	49.51	38.00
39.00	Central Services and Supply	14.00	389,170	0	389,170	20,269.00	19.20	39.00
40.00	Pharmacy	15.00	3,313,230	0	3,313,230	80,517.00	41.15	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part II
Date/Time Prepared:
11/28/2016 2:11 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	1,153,269	0	1,153,269	60,908.00	18.93	41.00
42.00	Social Service	17.00	2,525,669	0	2,525,669	65,115.00	38.79	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part III
Date/Time Prepared:
11/28/2016 2:11 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es 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)	105,058,957	0	105,058,957	3,242,263.00	32.40	1.00
2.00	Excluded area salaries (see instructions)	135,897	0	135,897	5,567.00	24.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)	104,923,060	0	104,923,060	3,236,696.00	32.42	3.00
4.00	Subtotal other wages & related costs (see inst.)	40,560,382	0	40,560,382	620,690.00	65.35	4.00
5.00	Subtotal wage-related costs (see inst.)	19,520,848	0	19,520,848	0.00	18.60	5.00
6.00	Total (sum of lines 3 thru 5)	165,004,290	0	165,004,290	3,857,386.00	42.78	6.00
7.00	Total overhead cost (see instructions)	26,007,770	0	26,007,770	914,134.00	28.45	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2016 2:11 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,690,187	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)		1,186,176	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)		6,949,755	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		562,630	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		260,507	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		646,069	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		571,228	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		7,110,168	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		68,401	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		502,675	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		19,547,796	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part V Date/Time Prepared: 11/28/2016 2:11 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF			0 3.00
4.00	Subprovider - IRF			0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			0 8.00
9.00	Hospital-Based NF			0 9.00
10.00	Hospital-Based OLTC			0 10.00
11.00	Hospital-Based HHA			0 11.00
12.00	Separately Certified ASC			0 12.00
13.00	Hospital-Based Hospice			0 13.00
14.00	Hospital-Based Health Clinic RHC			0 14.00
15.00	Hospital-Based Health Clinic FQHC			0 15.00
16.00	Hospital-Based-CMHC			0 16.00
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-7

Date/Time Prepared:
11/28/2016 2:11 pm

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-7

Date/Time Prepared:
11/28/2016 2:11 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)
		1.00	2.00

201.00 SNF SERVICES
Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?
		1.00	2.00	3.00

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00	202.00
203.00	Recruitment	0	0.00	203.00
204.00	Retention of employees	0	0.00	204.00
205.00	Training	0	0.00	205.00
206.00	OTHER (SPECIFY)	0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0		207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/28/2016 2:11 pm
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				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)		0.197302		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		47,623,844		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		303,827,823		6.00
7.00	Medicaid cost (line 1 times line 6)		59,945,837		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)		12,321,993		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		12,321,993		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	26,881,065	0	26,881,065	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,303,688	0	5,303,688	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,303,688	0	5,303,688	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		18,831,392		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		953,155		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		17,878,237		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,527,412		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		8,831,100		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		21,153,093		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet A	
Date/Time Prepared: 11/28/2016 2:11 pm							
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		14,942,203	14,942,203	6,414,007	21,356,210	1.00
2.00	00200		0	0	10,179,273	10,179,273	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	129,867	11,646,595	11,776,462	571,228	12,347,690	4.00
5.00	00500	8,237,238	70,088,278	78,325,516	-2,190,301	76,135,215	5.00
7.00	00700	747,172	4,884,387	5,631,559	-11,888	5,619,671	7.00
8.00	00800	0	0	0	1,276,584	1,276,584	8.00
9.00	00900	1,264	6,078,967	6,080,231	-1,294,040	4,786,191	9.00
10.00	01000	68,011	4,757,308	4,825,319	-1,458,174	3,367,145	10.00
11.00	01100	0	699,651	699,651	1,458,174	2,157,825	11.00
13.00	01300	1,782,074	395,381	2,177,455	-39,926	2,137,529	13.00
14.00	01400	389,170	798,647	1,187,817	-411,187	776,630	14.00
15.00	01500	3,313,230	16,077,936	19,391,166	-12,512,491	6,878,675	15.00
16.00	01600	1,153,269	1,577,272	2,730,541	-72	2,730,469	16.00
17.00	01700	2,525,669	269,351	2,795,020	0	2,795,020	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	27,541,801	6,067,298	33,609,099	-1,095,484	32,513,615	30.00
31.00	03100	4,538,704	1,511,195	6,049,899	-544,727	5,505,172	31.00
31.01	02060	6,275,661	1,562,685	7,838,346	-288,716	7,549,630	31.01
43.00	04300	781,978	77,215	859,193	-317	858,876	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,200,506	9,657,760	14,858,266	-6,555,621	8,302,645	50.00
50.01	05001	1,404,060	1,854,644	3,258,704	-1,450,635	1,808,069	50.01
51.00	05100	1,128,617	189,831	1,318,448	-52,522	1,265,926	51.00
52.00	05200	4,030,403	1,277,693	5,308,096	-490,635	4,817,461	52.00
53.00	05300	92,551	505,098	597,649	-247,248	350,401	53.00
54.00	05400	2,581,567	464,151	3,045,718	-48,828	2,996,890	54.00
54.01	03630	1,165,010	157,163	1,322,173	-30,295	1,291,878	54.01
54.02	05401	660,054	716,304	1,376,358	-600,291	776,067	54.02
54.03	03440	1,057,262	635,630	1,692,892	-416,712	1,276,180	54.03
55.00	05500	817,478	239,740	1,057,218	-150,787	906,431	55.00
56.00	05600	428,601	1,232,416	1,661,017	-4,757	1,656,260	56.00
57.00	05700	1,043,611	551,365	1,594,976	-408,689	1,186,287	57.00
58.00	05800	739,320	824,445	1,563,765	-695,323	868,442	58.00
59.00	05900	1,462,213	2,700,712	4,162,925	-2,377,121	1,785,804	59.00
60.00	06000	2,358,330	6,397,760	8,756,090	-9,033	8,747,057	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	383,407	939,248	1,322,655	-9,631	1,313,024	63.00
64.00	06400	259,336	380,915	640,251	-310,534	329,717	64.00
65.00	06500	1,847,384	1,230,528	3,077,912	-513,802	2,564,110	65.00
66.00	06600	2,204,760	205,932	2,410,692	-579	2,410,113	66.00
66.01	06601	1,538,925	559,503	2,098,428	-299,034	1,799,394	66.01
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	952,180	140,225	1,092,405	-10,350	1,082,055	69.00
70.00	07000	191,336	22,980	214,316	0	214,316	70.00
71.00	07100	0	0	0	11,491,097	11,491,097	71.00
72.00	07200	0	12,000,711	12,000,711	2,312,929	14,313,640	72.00
73.00	07300	0	0	0	11,491,117	11,491,117	73.00
74.00	07400	0	907,039	907,039	-2,249	904,790	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	2,067,108	808,551	2,875,659	-521,144	2,354,515	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	175,193	103,012	278,205	0	278,205	90.04
90.05	09003	441,844	326,090	767,934	-235,044	532,890	90.05
91.00	09100	6,725,561	3,293,775	10,019,336	-735,426	9,283,910	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		9,170,796	9,170,796	-9,170,796	0	113.00
118.00		98,441,725	198,928,386	297,370,111	0	297,370,111	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	135,645	752,395	888,040	0	888,040	190.00
192.00	19200	0	975,618	975,618	0	975,618	192.00
192.01	19201	0	4,100,342	4,100,342	0	4,100,342	192.01
194.00	07950	252	19	271	0	271	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		98,577,622	204,756,760	303,334,382	0	303,334,382	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A
Date/Time Prepared:
11/28/2016 2:11 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	8,377,481	29,733,691	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,666,992	8,512,281	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,360,683	13,708,373	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-507,214	75,628,001	5.00
7.00	00700	OPERATION OF PLANT	4,217,528	9,837,199	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,276,584	8.00
9.00	00900	HOUSEKEEPING	0	4,786,191	9.00
10.00	01000	DIETARY	-10,355	3,356,790	10.00
11.00	01100	CAFETERIA	-1,026,947	1,130,878	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,137,529	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	776,630	14.00
15.00	01500	PHARMACY	0	6,878,675	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	186,848	2,917,317	16.00
17.00	01700	SOCIAL SERVICE	0	2,795,020	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-433,026	32,080,589	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,505,172	31.00
31.01	02060	NEONATAL NICU	0	7,549,630	31.01
43.00	04300	NURSERY	0	858,876	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	8,302,645	50.00
50.01	05001	ENDOSCOPY	0	1,808,069	50.01
51.00	05100	RECOVERY ROOM	0	1,265,926	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,817,461	52.00
53.00	05300	ANESTHESIOLOGY	0	350,401	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,996,890	54.00
54.01	03630	ULTRASOUND	0	1,291,878	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	776,067	54.02
54.03	03440	MAMMOGRAPHY	0	1,276,180	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	906,431	55.00
56.00	05600	RADIOISOTOPE	0	1,656,260	56.00
57.00	05700	CT SCAN	0	1,186,287	57.00
58.00	05800	MRI	0	868,442	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,785,804	59.00
60.00	06000	LABORATORY	-74,043	8,673,014	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,313,024	63.00
64.00	06400	INTRAVENOUS THERAPY	0	329,717	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,564,110	65.00
66.00	06600	PHYSICAL THERAPY	0	2,410,113	66.00
66.01	06601	REHAB OUTPATIENT	0	1,799,394	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,082,055	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	214,316	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,491,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,313,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,491,117	73.00
74.00	07400	RENAL DIALYSIS	0	904,790	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.02	09001	PROCEDURE CLINIC	0	2,354,515	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	278,205	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	532,890	90.05
91.00	09100	EMERGENCY	-14,451	9,269,459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,409,512	307,779,623	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-495,152	392,888	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-839,582	136,036	192.00
192.01	19201	POB	-4,714,063	-613,721	192.01
194.00	07950	COMMUNITY PROGRAMS	0	271	194.00
194.01	07951	VACANT SPACE	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	4,360,715	307,695,097	200.00

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6

Date/Time Prepared:
11/28/2016 2:11 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,105,995	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,316,489	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
TOTALS			0	7,422,484	
B - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	11,491,097	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	193,982	2.00
3.00	OPERATION OF PLANT	7.00	0	17	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
TOTALS			0	11,685,096	
C - RECLASS CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,491,117	1.00
TOTALS			0	11,491,117	
D - RECLASS DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,862,784	1.00
TOTALS			0	4,862,784	

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6

Date/Time Prepared:
11/28/2016 2:11 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
E - RECLASS LAUNDRY COSTS						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	1,276,584	1.00	
	TOTALS		0	1,276,584		
F - RECLASS CAFETERIA COSTGS						
1.00	CAFETERIA	11.00	26,562	1,431,612	1.00	
	TOTALS		26,562	1,431,612		
G - RECLASS WORKERS COMPENSATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	571,228	1.00	
	TOTALS		0	571,228		
H - RECLASS INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,170,796	1.00	
	TOTALS		0	9,170,796		
I - RECLASS NEGATIVE SALARIES						
1.00		0.00	0	0	1.00	
	TOTALS		0	0		
J - IMPLANT RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,517,361	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
	TOTALS		0	2,517,361		
500.00	Grand Total: Increases		26,562	50,429,062	500.00	

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6
Date/Time Prepared:
11/28/2016 2:11 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - RECLASS LEASE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,813,055	10		1.00
2.00	OPERATION OF PLANT	7.00	0	11,905	10		2.00
3.00	HOUSEKEEPING	9.00	0	17,456	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	35,652	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	399,295	0		5.00
6.00	PHARMACY	15.00	0	771,152	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	72	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	426,697	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	186,010	0		9.00
10.00	NEONATAL NICU	31.01	0	7,355	0		10.00
11.00	OPERATING ROOM	50.00	0	648,037	0		11.00
12.00	ENDOSCOPY	50.01	0	811,276	0		12.00
13.00	RECOVERY ROOM	51.00	0	7,253	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	276	0		14.00
15.00	MAMMOGRAPHY	54.03	0	337,290	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	141,060	0		16.00
17.00	CT SCAN	57.00	0	144,271	0		17.00
18.00	MRI	58.00	0	543,288	0		18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	82,752	0		19.00
20.00	LABORATORY	60.00	0	4,469	0		20.00
21.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	6,664	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	444,680	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	60	0		23.00
24.00	REHAB OUTPATIENT	66.01	0	298,284	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	2,496	0		25.00
26.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	13,261	0		26.00
27.00	PROCEDURE CLINIC	90.02	0	40,411	0		27.00
28.00	OFFSITE IMAGING CENTER	90.05	0	226,777	0		28.00
29.00	EMERGENCY	91.00	0	1,230	0		29.00
TOTALS			0	7,422,484			
B - RECLASS MEDICAL SUPPLIES							
1.00	NURSING ADMINISTRATION	13.00	0	4,274	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,933	0		2.00
3.00	PHARMACY	15.00	0	250,063	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	668,787	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	358,717	0		5.00
6.00	NEONATAL NICU	31.01	0	281,361	0		6.00
7.00	NURSERY	43.00	0	317	0		7.00
8.00	OPERATING ROOM	50.00	0	5,907,584	0		8.00
9.00	ENDOSCOPY	50.01	0	573,566	0		9.00
10.00	RECOVERY ROOM	51.00	0	45,269	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	480,574	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	245,707	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	48,552	0		13.00
14.00	ULTRASOUND	54.01	0	30,295	0		14.00
15.00	RADIOLOGY-SPECIAL PROCEDURES	54.02	0	362,267	0		15.00
16.00	MAMMOGRAPHY	54.03	0	79,422	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	9,727	0		17.00
18.00	RADIOISOTOPE	56.00	0	4,757	0		18.00
19.00	CT SCAN	57.00	0	264,418	0		19.00
20.00	MRI	58.00	0	152,035	0		20.00
21.00	CARDIAC CATHETERIZATION	59.00	0	470,423	0		21.00
22.00	LABORATORY	60.00	0	4,564	0		22.00
23.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	2,967	0		23.00
24.00	INTRAVENOUS THERAPY	64.00	0	310,534	0		24.00
25.00	RESPIRATORY THERAPY	65.00	0	69,122	0		25.00
26.00	PHYSICAL THERAPY	66.00	0	519	0		26.00
27.00	REHAB OUTPATIENT	66.01	0	750	0		27.00
28.00	ELECTROCARDIOLOGY	69.00	0	7,854	0		28.00
29.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	191,171	0		29.00
30.00	RENAL DIALYSIS	74.00	0	2,249	0		30.00
31.00	PROCEDURE CLINIC	90.02	0	104,000	0		31.00
32.00	OFFSITE IMAGING CENTER	90.05	0	8,267	0		32.00
33.00	EMERGENCY	91.00	0	734,051	0		33.00
TOTALS			0	11,685,096			
C - RECLASS CHARGEABLE DRUGS							
1.00	PHARMACY	15.00	0	11,491,117	0		1.00
TOTALS			0	11,491,117			

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6

Date/Time Prepared:
11/28/2016 2:11 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
D - RECLASS DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,862,784	9	1.00
	TOTALS		0	4,862,784		
E - RECLASS LAUNDRY COSTS						
1.00	HOUSEKEEPING	9.00	0	1,276,584	0	1.00
	TOTALS		0	1,276,584		
F - RECLASS CAFETERIA COSTGS						
1.00	DIETARY	10.00	26,562	1,431,612	0	1.00
	TOTALS		26,562	1,431,612		
G - RECLASS WORKERS COMPENSATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	571,228	0	1.00
	TOTALS		0	571,228		
H - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	9,170,796	11	1.00
	TOTALS		0	9,170,796		
I - RECLASS NEGATIVE SALARIES						
1.00		0.00	0	0	0	1.00
	TOTALS		0	0		
J - IMPLANT RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	959	0	1.00
2.00	PHARMACY	15.00	0	159	0	2.00
3.00	ENDOSCOPY	50.01	0	65,793	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	10,061	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	1,541	0	5.00
6.00	RADIOLOGY-SPECIAL PROCEDURES	54.02	0	238,024	0	6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	1,823,946	0	7.00
8.00	PROCEDURE CLINIC	90.02	0	376,733	0	8.00
9.00	EMERGENCY	91.00	0	145	0	9.00
	TOTALS		0	2,517,361		
500.00	Grand Total : Decreases		26,562	50,429,062		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part I
Date/Time Prepared:
11/28/2016 2:11 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	12,220,000	0	0	0	1.00
2.00	Land Improvements	185,321	0	0	0	2.00
3.00	Buildings and Fixtures	222,953,591	2,832,179	0	2,832,179	3.00
4.00	Building Improvements	28,493,324	124,654	0	124,654	4.00
5.00	Fixed Equipment	1,460,605	0	0	0	5.00
6.00	Movable Equipment	37,492,350	5,622,546	0	5,622,546	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	302,805,191	8,579,379	0	8,579,379	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	302,805,191	8,579,379	0	8,579,379	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	12,220,000	0			1.00
2.00	Land Improvements	185,321	0			2.00
3.00	Buildings and Fixtures	225,785,770	0			3.00
4.00	Building Improvements	28,594,524	0			4.00
5.00	Fixed Equipment	1,460,605	0			5.00
6.00	Movable Equipment	43,104,269	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	311,350,489	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	311,350,489	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part II
Date/Time Prepared:
11/28/2016 2:11 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	14,942,203	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,942,203	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	14,942,203				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	14,942,203				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part III
Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	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	268,246,220	0	268,246,220	0.861557	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	43,104,269	0	43,104,269	0.138443	0	2.00
3.00	Total (sum of lines 1-2)	311,350,489	0	311,350,489	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	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	19,859,985	2,105,995	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,195,792	5,316,489	2.00
3.00	Total (sum of lines 1-2)	0	0	0	23,055,777	7,422,484	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	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	7,767,711	0	0	0	29,733,691	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	8,512,281	2.00
3.00	Total (sum of lines 1-2)	7,767,711	0	0	0	38,245,972	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8

Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-142,547	CAP REL COSTS-BLDG & FIXT	1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-17,364	CAP REL COSTS-MVBLE EQUIP	2.00	9 2.00
3.00 Investment income - other (chapter 2)		0		0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0 7.00
8.00 Television and radio service (chapter 21)		0		0.00	0 8.00
9.00 Parking lot (chapter 21)		0		0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-498,902			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	15,823,340			0 12.00
13.00 Laundry and linen service		0		0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-1,026,947	CAFETERIA	11.00	0 14.00
15.00 Rental of quarters to employee and others		0		0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00
17.00 Sale of drugs to other than patients		0		0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-54,666	MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0 19.00
20.00 Vending machines	B	-10,355	DIETARY	10.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-997,724	CAP REL COSTS-BLDG & FIXT	1.00	9 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,649,628	CAP REL COSTS-MVBLE EQUIP	2.00	9 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0 32.00
33.00		0		0.00	0 33.00
34.00		0		0.00	0 34.00

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8

Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
34.01 CAFETERIA REVENUE	B	-495,152	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0 34.01
34.02 LAB OTHER REVENUE	B	-69,981	LABORATORY	60.00	0 34.02
34.03 LAB OTHER REVENUE	B	-1,665	LABORATORY	60.00	0 34.03
34.04 LAB OTHER REVENUE	B	-76	LABORATORY	60.00	0 34.04
34.05 LAB OTHER REVENUE	B	-1,863	LABORATORY	60.00	0 34.05
34.06 LAB OTHER REVENUE	B	-458	LABORATORY	60.00	0 34.06
34.07		0		0.00	0 34.07
35.00 ITC RENT REV ABSG	B	-50,816	POB	192.01	0 35.00
36.00 ITC RENT REV ABAG	B	-192,045	POB	192.01	0 36.00
37.00 ITC RENT REV ABSG	B	-140,004	POB	192.01	0 37.00
38.00		0		0.00	0 38.00
38.01		0		0.00	0 38.01
39.00		0		0.00	0 39.00
40.00 PERINATAL CLASS TUI TION	B	-63,073	ADMINISTRATIVE & GENERAL	5.00	0 40.00
41.00 OTHER EDUCATION	B	-964	ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00		0		0.00	0 42.00
43.00 AUDIT RECOVERIES	B	-600	ADMINISTRATIVE & GENERAL	5.00	0 43.00
43.01 ITC RENT REV	B	-5,778	ADMINISTRATIVE & GENERAL	5.00	0 43.01
43.02 ITC RENT REV ABSG	B	-236,730	ADMINISTRATIVE & GENERAL	5.00	0 43.02
43.03		0		0.00	0 43.03
43.04 MISCELLANEOUS INCOME	B	-23,894	OPERATION OF PLANT	7.00	0 43.04
43.05		0		0.00	0 43.05
43.06 RENT PHYS OFFICE	B	-94,154	POB	192.01	0 43.06
43.07 RENT PHYS OFFICE	B	-1,216,459	POB	192.01	0 43.07
43.08		0		0.00	0 43.08
43.09		0		0.00	0 43.09
43.10		0		0.00	0 43.10
43.11 RENT PHYS OFFICE	B	-281,585	POB	192.01	0 43.11
43.12 RENT PHYS OFFICE	B	-17,895	POB	192.01	0 43.12
43.13 INCOME FROM EASEMENT	B	-23,833	ADMINISTRATIVE & GENERAL	5.00	0 43.13
43.14 COMMUNITY TRANSPORT	A	-8,623	ADMINISTRATIVE & GENERAL	5.00	0 43.14
43.15 R/E TAXES	A	-261,171	ADMINISTRATIVE & GENERAL	5.00	0 43.15
43.16 CONTRIBUTIONS	A	-5,000	ADMINISTRATIVE & GENERAL	5.00	0 43.16
43.17 ER DIRECT PT SVSC	A	-14,451	EMERGENCY	91.00	0 43.17
43.18 NON PATIENT RELATED COSTS	A	-32,472	ADMINISTRATIVE & GENERAL	5.00	0 43.18
43.19 OFFSET PHYSICIAN FEES	A	-839,582	PHYSICIANS' PRIVATE OFFICES	192.00	0 43.19
43.20 OFFSET PHYSICIAN FEES	A	-644,188	POB	192.01	0 43.20
43.21 OFFSET PHYSICIAN FEES	A	-1,176,632	POB	192.01	0 43.21
43.22 OFFSET PHYSICIAN FEES	A	-900,285	POB	192.01	0 43.22
43.23 LOBBY DUES	A	-43,832	ADMINISTRATIVE & GENERAL	5.00	0 43.23
43.24 NON PATIENT RELATED COSTS	A	-221,231	ADMINISTRATIVE & GENERAL	5.00	0 43.24
43.25		0		0.00	0 43.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		4,360,715			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: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8-1

Date/Time Prepared:
11/28/2016 2:11 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	5.00	ADMINISTRATIVE & GENERAL	ABHN NON CAP	45,559,778	23,181,261 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ABHS NON CAP	0	21,848,580 2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	241,514	0 3.00
3.01	7.00	OPERATION OF PLANT	PLANT OPERATIONS	4,241,422	0 3.01
3.02	1.00	CAP REL COSTS-BLDG & FIXT	ABHN CAPITAL	4,917,888	0 3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS	1,360,683	0 3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	EXECUTIVE SALARIES	1,259,545	1,327,513 3.04
3.05	1.00	CAP REL COSTS-BLDG & FIXT	ABHN CAPITAL	5,860,402	0 3.05
3.06	1.00	CAP REL COSTS-BLDG & FIXT	ABHN INTEREST OFFSET	-1,260,538	0 3.06
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			62,180,694	46,357,354 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.

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

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

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

6.00	B	0.00	ABHS	100.00	6.00
7.00	B	0.00	ABHN	100.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8-1

Date/Time Prepared:
11/28/2016 2:11 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	22,378,517	0		1.00
2.00	-21,848,580	0		2.00
3.00	241,514	0		3.00
3.01	4,241,422	0		3.01
3.02	4,917,888	9		3.02
3.03	1,360,683	0		3.03
3.04	-67,968	0		3.04
3.05	5,860,402	9		3.05
3.06	-1,260,538	11		3.06
4.00	0	0		4.00
5.00	15,823,340			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	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00			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: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8-2

Date/Time Prepared:
11/28/2016 2:11 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	30.00	ADULTS & PEDIATRICS	433,026	433,026	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	65,876	65,876	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			498,902	498,902	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	433,026	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	65,876	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	498,902	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part I
Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	29,733,691	29,733,691			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	8,512,281		8,512,281		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	13,708,373	21,125	6,110	13,735,608	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	75,628,001	2,723,330	699,362	1,149,276	5.00
7.00 00700	OPERATION OF PLANT	9,837,199	8,109,950	2,345,854	104,247	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,276,584	0	0	0	8.00
9.00 00900	HOUSEKEEPING	4,786,191	340,967	98,627	176	9.00
10.00 01000	DIETARY	3,356,790	303,128	87,682	5,783	10.00
11.00 01100	CAFETERIA	1,130,878	220,014	63,640	3,706	11.00
13.00 01300	NURSING ADMINISTRATION	2,137,529	484,020	140,006	248,639	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	776,630	152,538	44,123	54,298	14.00
15.00 01500	PHARMACY	6,878,675	221,398	64,041	462,268	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,917,317	338,660	97,960	160,906	16.00
17.00 01700	SOCIAL SERVICE	2,795,020	14,818	4,286	352,386	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	32,080,589	6,798,172	1,966,415	3,842,668	30.00
31.00 03100	INTENSIVE CARE UNIT	5,505,172	553,136	159,998	633,249	31.00
31.01 02060	NEONATAL NICU	7,549,630	1,008,187	291,624	875,593	31.01
43.00 04300	NURSERY	858,876	65,630	18,984	109,103	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8,302,645	1,689,147	488,597	725,585	50.00
50.01 05001	ENDOSCOPY	1,808,069	543,958	157,343	195,897	50.01
51.00 05100	RECOVERY ROOM	1,265,926	290,412	84,004	157,467	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,817,461	768,638	222,333	562,330	52.00
53.00 05300	ANESTHESIOLOGY	350,401	27,124	7,846	12,913	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,996,890	754,076	218,121	360,185	54.00
54.01 03630	ULTRASOUND	1,291,878	57,529	16,641	162,545	54.01
54.02 05401	RADIOLOGY-SPECIAL PROCEDURES	776,067	52,811	15,276	92,092	54.02
54.03 03440	MAMMOGRAPHY	1,276,180	251,598	72,776	147,511	54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	906,431	637,224	184,321	114,056	55.00
56.00 05600	RADIOISOTOPE	1,656,260	109,058	31,546	59,799	56.00
57.00 05700	CT SCAN	1,186,287	136,592	39,510	145,607	57.00
58.00 05800	MRI	868,442	105,110	30,404	103,151	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,785,804	342,403	99,042	204,011	59.00
60.00 06000	LABORATORY	8,673,014	690,754	199,805	329,039	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,313,024	27,841	8,053	53,494	63.00
64.00 06400	INTRAVENOUS THERAPY	329,717	0	0	36,183	64.00
65.00 06500	RESPIRATORY THERAPY	2,564,110	73,680	21,312	257,751	65.00
66.00 06600	PHYSICAL THERAPY	2,410,113	274,158	79,302	307,613	66.00
66.01 06601	REHAB OUTPATIENT	1,799,394	6,102	1,765	214,714	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	1,082,055	0	0	132,850	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	214,316	28,508	8,246	26,696	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,491,097	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	14,313,640	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	11,491,117	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	904,790	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001	PROCEDURE CLINIC	2,354,515	326,713	94,504	288,407	90.02
90.03 09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04 09002	EPILEPSY MONITORING UNIT	278,205	0	0	24,443	90.04
90.05 09003	OFFSITE IMAGING CENTER	532,890	0	0	61,647	90.05
91.00 09100	EMERGENCY	9,269,459	1,063,408	307,598	938,364	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	307,779,623	29,611,917	8,477,057	13,716,648	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	392,888	121,774	35,224	18,925	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	136,036	0	0	0	192.00
192.01 19201	POB	-613,721	0	0	0	192.01
194.00 07950	COMMUNITY PROGRAMS	271	0	0	35	194.00
194.01 07951	VACANT SPACE	0	0	0	0	194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
202.00 TOTAL (sum lines 118-201)	307,695,097	29,733,691	8,512,281	13,735,608	307,695,097	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part I Date/Time Prepared: 11/28/2016 2:11 pm
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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	80,199,969				5.00
7.00	00700	OPERATION OF PLANT	7,171,388	27,568,638			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	448,829		1,725,413		8.00
9.00	00900	HOUSEKEEPING	1,837,375	497,900	0	7,561,236	9.00
10.00	01000	DIETARY	1,319,637	442,645	0	123,637	10.00
11.00	01100	CAFETERIA	498,633	321,277	0	89,737	11.00
13.00	01300	NURSING ADMINISTRATION	1,058,342	706,794	0	197,417	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	361,286	222,745	0	62,216	14.00
15.00	01500	PHARMACY	2,681,329	323,298	0	90,302	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,235,770	494,531	0	138,129	16.00
17.00	01700	SOCIAL SERVICE	1,113,301	21,638	0	6,044	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,711,710	9,927,089	983,117	2,772,774	30.00
31.00	03100	INTENSIVE CARE UNIT	2,408,911	807,722	86,206	225,608	31.00
31.01	02060	NEONATAL NICU	3,419,186	1,472,213	14,782	411,210	31.01
43.00	04300	NURSERY	370,077	95,836	0	26,768	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,939,864	2,466,592	204,102	688,954	50.00
50.01	05001	ENDOSCOPY	951,134	794,320	0	221,865	50.01
51.00	05100	RECOVERY ROOM	632,084	424,076	0	118,450	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,239,871	1,122,410	110,185	313,505	52.00
53.00	05300	ANESTHESIOLOGY	140,031	39,607	0	11,063	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,522,111	1,101,146	4,245	307,566	54.00
54.01	03630	ULTRASOUND	537,432	84,007	49,171	23,464	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	329,171	77,118	0	21,540	54.02
54.03	03440	MAMMOGRAPHY	614,595	367,398	0	102,619	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	647,633	930,512	13,117	259,905	55.00
56.00	05600	RADIOISOTOPE	652,777	159,253	0	44,482	56.00
57.00	05700	CT SCAN	530,190	199,460	60,354	55,712	57.00
58.00	05800	MRI	389,243	153,488	0	42,871	58.00
59.00	05900	CARDIAC CATHETERIZATION	854,797	499,997	0	139,656	59.00
60.00	06000	LABORATORY	3,478,104	1,008,679	0	281,738	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	493,068	40,656	0	11,356	63.00
64.00	06400	INTRAVENOUS THERAPY	128,645	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,025,525	107,591	0	30,052	65.00
66.00	06600	PHYSICAL THERAPY	1,079,786	400,342	0	111,821	66.00
66.01	06601	REHAB OUTPATIENT	710,898	8,910	0	2,489	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	427,144	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,659	41,629	0	11,628	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,040,109	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,032,475	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,040,116	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	318,111	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	PROCEDURE CLINIC	1,077,308	477,086	0	133,257	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	106,407	0	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	209,031	0	0	0	90.05
91.00	09100	EMERGENCY	4,070,954	1,552,851	200,134	433,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	79,952,047	27,390,816	1,725,413	7,511,568	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	199,986	177,822	0	49,668	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,828	0	0	0	192.00
192.01	19201	POB	0	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	108	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	80,199,969	27,568,638	1,725,413	7,561,236	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part I
Date/Time Prepared:
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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	2,327,885					11.00
13.00	01300	NURSING ADMINISTRATION	31,173	5,003,920				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,157	0	1,692,993			14.00
15.00	01500	PHARMACY	70,362	0	0	10,791,673		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,526	0	0	0	5,435,799	16.00
17.00	01700	SOCIAL SERVICE	57,204	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	781,155	2,566,755	0	0	621,278	30.00
31.00	03100	INTENSIVE CARE UNIT	101,677	334,095	0	0	83,127	31.00
31.01	02060	NEONATAL NICU	129,744	426,316	0	0	162,740	31.01
43.00	04300	NURSERY	18,711	61,481	0	0	38,454	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	123,459	405,666	0	0	460,563	50.00
50.01	05001	ENDOSCOPY	34,886	114,631	0	0	192,429	50.01
51.00	05100	RECOVERY ROOM	22,764	74,797	0	0	79,134	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	92,340	303,414	0	0	111,622	52.00
53.00	05300	ANESTHESIOLOGY	3,910	0	0	0	105,174	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,876	0	0	0	145,830	54.00
54.01	03630	ULTRASOUND	22,656	0	0	0	118,508	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	12,623	0	0	0	30,526	54.02
54.03	03440	MAMMOGRAPHY	26,352	0	0	0	59,948	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	13,319	0	0	0	72,560	55.00
56.00	05600	RADIOISOTOPE	7,909	0	0	0	87,663	56.00
57.00	05700	CT SCAN	23,513	0	0	0	342,509	57.00
58.00	05800	MRI	17,354	0	0	0	164,856	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,281	0	0	0	100,402	59.00
60.00	06000	LABORATORY	92,786	0	0	0	634,467	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,534	0	0	0	28,679	63.00
64.00	06400	INTRAVENOUS THERAPY	5,374	0	0	0	12,611	64.00
65.00	06500	RESPIRATORY THERAPY	48,652	0	0	0	117,263	65.00
66.00	06600	PHYSICAL THERAPY	42,992	0	0	0	72,045	66.00
66.01	06601	REHAB OUTPATIENT	37,439	0	0	0	40,150	66.01
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	24,906	0	0	0	128,645	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,106	0	0	0	16,242	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	756,093	0	278,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	936,900	0	95,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,791,673	485,859	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	15,196	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	44,510	146,251	0	0	47,542	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	3,785	12,437	0	0	3,302	90.04
90.05	09003	OFFSITE IMAGING CENTER	11,748	0	0	0	40,120	90.05
91.00	09100	EMERGENCY	169,843	558,077	0	0	442,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,275,626	5,003,920	1,692,993	10,791,673	5,435,799	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,515	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,463	0	0	0	0	192.00
192.01	19201	POB	27,281	0	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,327,885	5,003,920	1,692,993	10,791,673	5,435,799	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part I
Date/Time Prepared:
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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	4,364,697			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,314,044	86,602,819	0	30.00
31.00	03100	INTENSIVE CARE UNIT	270,406	11,571,556	0	31.00
31.01	02060	NEONATAL NICU	404,958	16,166,183	0	31.01
43.00	04300	NURSERY	375,289	2,039,209	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	19,495,174	0	50.00
50.01	05001	ENDOSCOPY	0	5,014,532	0	50.01
51.00	05100	RECOVERY ROOM	0	3,149,114	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,664,109	0	52.00
53.00	05300	ANESTHESIOLOGY	0	698,069	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,500,046	0	54.00
54.01	03630	ULTRASOUND	0	2,363,831	0	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	1,407,224	0	54.02
54.03	03440	MAMMOGRAPHY	0	2,918,977	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,779,078	0	55.00
56.00	05600	RADIOISOTOPE	0	2,808,747	0	56.00
57.00	05700	CT SCAN	0	2,719,734	0	57.00
58.00	05800	MRI	0	1,874,919	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,049,393	0	59.00
60.00	06000	LABORATORY	0	15,388,386	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,987,705	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	512,530	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,245,936	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,778,172	0	66.00
66.01	06601	REHAB OUTPATIENT	0	2,821,861	0	66.01
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	1,795,600	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	451,030	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,566,233	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,378,074	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,808,765	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,238,097	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02	09001	PROCEDURE CLINIC	0	4,990,093	0	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	428,579	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	855,436	0	90.05
91.00	09100	EMERGENCY	0	19,006,783	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,364,697	307,075,994	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,011,802	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	193,327	0	192.00
192.01	19201	POB	0	-586,440	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	414	0	194.00
194.01	07951	VACANT SPACE	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,364,697	307,695,097	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	21,125	6,110	27,235	27,235 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	2,723,330	699,362	3,422,692	2,282 5.00
7.00 00700	OPERATION OF PLANT	0	8,109,950	2,345,854	10,455,804	207 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	0	340,967	98,627	439,594	0 9.00
10.00 01000	DIETARY	0	303,128	87,682	390,810	11 10.00
11.00 01100	CAFETERIA	0	220,014	63,640	283,654	7 11.00
13.00 01300	NURSING ADMINISTRATION	0	484,020	140,006	624,026	494 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	152,538	44,123	196,661	108 14.00
15.00 01500	PHARMACY	0	221,398	64,041	285,439	918 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	338,660	97,960	436,620	319 16.00
17.00 01700	SOCIAL SERVICE	0	14,818	4,286	19,104	700 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	6,798,172	1,966,415	8,764,587	7,592 30.00
31.00 03100	INTENSIVE CARE UNIT	0	553,136	159,998	713,134	1,257 31.00
31.01 02060	NEONATAL NICU	0	1,008,187	291,624	1,299,811	1,738 31.01
43.00 04300	NURSERY	0	65,630	18,984	84,614	217 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	1,689,147	488,597	2,177,744	1,441 50.00
50.01 05001	ENDOSCOPY	0	543,958	157,343	701,301	389 50.01
51.00 05100	RECOVERY ROOM	0	290,412	84,004	374,416	313 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	768,638	222,333	990,971	1,116 52.00
53.00 05300	ANESTHESIOLOGY	0	27,124	7,846	34,970	26 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	754,076	218,121	972,197	715 54.00
54.01 03630	ULTRASOUND	0	57,529	16,641	74,170	323 54.01
54.02 05401	RADIOLOGY-SPECIAL PROCEDURES	0	52,811	15,276	68,087	183 54.02
54.03 03440	MAMMOGRAPHY	0	251,598	72,776	324,374	293 54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	0	637,224	184,321	821,545	226 55.00
56.00 05600	RADIOISOTOPE	0	109,058	31,546	140,604	119 56.00
57.00 05700	CT SCAN	0	136,592	39,510	176,102	289 57.00
58.00 05800	MRI	0	105,110	30,404	135,514	205 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	342,403	99,042	441,445	405 59.00
60.00 06000	LABORATORY	0	690,754	199,805	890,559	653 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	27,841	8,053	35,894	106 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	72 64.00
65.00 06500	RESPIRATORY THERAPY	0	73,680	21,312	94,992	512 65.00
66.00 06600	PHYSICAL THERAPY	0	274,158	79,302	353,460	611 66.00
66.01 06601	REHAB OUTPATIENT	0	6,102	1,765	7,867	426 66.01
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	264 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	28,508	8,246	36,754	53 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001	PROCEDURE CLINIC	0	326,713	94,504	421,217	573 90.02
90.03 09004	IMMEDIATE CARE CENTER	0	0	0	0	0 90.03
90.04 09002	EPILEPSY MONITORING UNIT	0	0	0	0	49 90.04
90.05 09003	OFFSITE IMAGING CENTER	0	0	0	0	122 90.05
91.00 09100	EMERGENCY	0	1,063,408	307,598	1,371,006	1,863 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	29,611,917	8,477,057	38,088,974	27,197 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	121,774	35,224	156,998	38 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	POB	0	0	0	0	0 192.01
194.00 07950	COMMUNITY PROGRAMS	0	0	0	0	0 194.00
194.01 07951	VACANT SPACE	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	29,733,691	8,512,281	38,245,972	27,235 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part II
Date/Time Prepared:
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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	3,424,974				5.00
7.00	00700	OPERATION OF PLANT	306,265	10,762,276			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,168	0	19,168		8.00
9.00	00900	HOUSEKEEPING	78,468	194,371	0	712,433	9.00
10.00	01000	DIETARY	56,357	172,800	0	11,649	631,627
11.00	01100	CAFETERIA	21,295	125,420	0	8,455	0
13.00	01300	NURSING ADMINISTRATION	45,198	275,919	0	18,601	0
14.00	01400	CENTRAL SERVICES & SUPPLY	15,429	86,955	0	5,862	0
15.00	01500	PHARMACY	114,510	126,210	0	8,508	0
16.00	01600	MEDICAL RECORDS & LIBRARY	52,775	193,056	0	13,015	0
17.00	01700	SOCIAL SERVICE	47,545	8,447	0	569	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	670,906	3,875,350	10,923	261,257	586,573
31.00	03100	INTENSIVE CARE UNIT	102,876	315,319	958	21,257	45,054
31.01	02060	NEONATAL NICU	146,021	574,724	164	38,745	0
43.00	04300	NURSERY	15,805	37,413	0	2,522	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	168,258	962,911	2,267	64,914	0
50.01	05001	ENDOSCOPY	40,620	310,087	0	20,904	0
51.00	05100	RECOVERY ROOM	26,994	165,551	0	11,161	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	95,657	438,168	1,224	29,539	0
53.00	05300	ANESTHESIOLOGY	5,980	15,462	0	1,042	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,004	429,867	47	28,979	0
54.01	03630	ULTRASOUND	22,952	32,795	546	2,211	0
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	14,058	30,106	0	2,030	0
54.03	03440	MAMMOGRAPHY	26,247	143,425	0	9,669	0
55.00	05500	RADIOLOGY-THERAPEUTIC	27,658	363,254	146	24,489	0
56.00	05600	RADIOISOTOPE	27,878	62,169	0	4,191	0
57.00	05700	CT SCAN	22,643	77,865	670	5,249	0
58.00	05800	MRI	16,623	59,919	0	4,039	0
59.00	05900	CARDIAC CATHETERIZATION	36,505	195,189	0	13,159	0
60.00	06000	LABORATORY	148,538	393,769	0	26,546	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	21,057	15,871	0	1,070	0
64.00	06400	INTRAVENOUS THERAPY	5,494	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	43,797	42,002	0	2,832	0
66.00	06600	PHYSICAL THERAPY	46,114	156,286	0	10,536	0
66.01	06601	REHAB OUTPATIENT	30,360	3,478	0	234	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	18,242	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	4,171	16,251	0	1,096	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	172,539	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	214,919	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	172,539	0	0	0	0
74.00	07400	RENAL DIALYSIS	13,585	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	PROCEDURE CLINIC	46,008	186,245	0	12,556	0
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	0
90.04	09002	EPILEPSY MONITORING UNIT	4,544	0	0	0	0
90.05	09003	OFFSITE IMAGING CENTER	8,927	0	0	0	0
91.00	09100	EMERGENCY	173,856	606,204	2,223	40,867	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,414,385	10,692,858	19,168	707,753	631,627
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,541	69,418	0	4,680	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,043	0	0	0	0
192.01	19201	POB	0	0	0	0	0
194.00	07950	COMMUNITY PROGRAMS	5	0	0	0	0
194.01	07951	VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,424,974	10,762,276	19,168	712,433	631,627

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 11/28/2016 2: 11 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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	438,831					11.00
13.00	01300	5,876	970,114				13.00
14.00	01400	3,611	0	308,626			14.00
15.00	01500	13,264	0	0	548,849		15.00
16.00	01600	9,902	0	0	0	705,687	16.00
17.00	01700	10,783	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	147,256	497,619	0	0	80,572	30.00
31.00	03100	19,167	64,771	0	0	10,781	31.00
31.01	02060	24,458	82,650	0	0	21,105	31.01
43.00	04300	3,527	11,919	0	0	4,987	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	23,273	78,647	0	0	59,730	50.00
50.01	05001	6,576	22,224	0	0	24,956	50.01
51.00	05100	4,291	14,501	0	0	10,263	51.00
52.00	05200	17,407	58,823	0	0	14,476	52.00
53.00	05300	737	0	0	0	13,640	53.00
54.00	05400	16,943	0	0	0	18,912	54.00
54.01	03630	4,271	0	0	0	15,369	54.01
54.02	05401	2,380	0	0	0	3,959	54.02
54.03	03440	4,968	0	0	0	7,775	54.03
55.00	05500	2,511	0	0	0	9,410	55.00
56.00	05600	1,491	0	0	0	11,369	56.00
57.00	05700	4,433	0	0	0	44,419	57.00
58.00	05800	3,271	0	0	0	21,380	58.00
59.00	05900	4,389	0	0	0	13,021	59.00
60.00	06000	17,491	0	0	0	83,011	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	2,174	0	0	0	3,719	63.00
64.00	06400	1,013	0	0	0	1,636	64.00
65.00	06500	9,171	0	0	0	15,208	65.00
66.00	06600	8,104	0	0	0	9,343	66.00
66.01	06601	7,058	0	0	0	5,207	66.01
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	4,695	0	0	0	16,684	69.00
70.00	07000	1,151	0	0	0	2,106	70.00
71.00	07100	0	0	137,836	0	36,174	71.00
72.00	07200	0	0	170,790	0	12,328	72.00
73.00	07300	0	0	0	548,849	63,010	73.00
74.00	07400	0	0	0	0	1,971	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	8,391	28,354	0	0	6,166	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	714	2,411	0	0	428	90.04
90.05	09003	2,215	0	0	0	5,203	90.05
91.00	09100	32,017	108,195	0	0	57,369	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		428,979	970,114	308,626	548,849	705,687	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,925	0	0	0	0	190.00
192.00	19200	1,784	0	0	0	0	192.00
192.01	19201	5,143	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		438,831	970,114	308,626	548,849	705,687	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/28/2016 2:11 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	87,148			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	66,170	14,968,805	0	14,968,805	30.00
31.00	03100	INTENSIVE CARE UNIT	5,399	1,299,973	0	1,299,973	31.00
31.01	02060	NEONATAL NICU	8,086	2,197,502	0	2,197,502	31.01
43.00	04300	NURSERY	7,493	168,497	0	168,497	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,539,185	0	3,539,185	50.00
50.01	05001	ENDOSCOPY	0	1,127,057	0	1,127,057	50.01
51.00	05100	RECOVERY ROOM	0	607,490	0	607,490	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,647,381	0	1,647,381	52.00
53.00	05300	ANESTHESIOLOGY	0	71,857	0	71,857	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,532,664	0	1,532,664	54.00
54.01	03630	ULTRASOUND	0	152,637	0	152,637	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	120,803	0	120,803	54.02
54.03	03440	MAMMOGRAPHY	0	516,751	0	516,751	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,249,239	0	1,249,239	55.00
56.00	05600	RADIOISOTOPE	0	247,821	0	247,821	56.00
57.00	05700	CT SCAN	0	331,670	0	331,670	57.00
58.00	05800	MRI	0	240,951	0	240,951	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	704,113	0	704,113	59.00
60.00	06000	LABORATORY	0	1,560,567	0	1,560,567	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	79,891	0	79,891	63.00
64.00	06400	INTRAVENOUS THERAPY	0	8,215	0	8,215	64.00
65.00	06500	RESPIRATORY THERAPY	0	208,514	0	208,514	65.00
66.00	06600	PHYSICAL THERAPY	0	584,454	0	584,454	66.00
66.01	06601	REHAB OUTPATIENT	0	54,630	0	54,630	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,885	0	39,885	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	61,582	0	61,582	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	346,549	0	346,549	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	398,037	0	398,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	784,398	0	784,398	73.00
74.00	07400	RENAL DIALYSIS	0	15,556	0	15,556	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	PROCEDURE CLINIC	0	709,510	0	709,510	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	8,146	0	8,146	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	16,467	0	16,467	90.05
91.00	09100	EMERGENCY	0	2,393,600	0	2,393,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,148	37,994,397	0	37,994,397	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	242,600	0	242,600	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,827	0	3,827	192.00
192.01	19201	POB	0	5,143	0	5,143	192.01
194.00	07950	COMMUNITY PROGRAMS	0	5	0	5	194.00
194.01	07951	VACANT SPACE	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	87,148	38,245,972	0	38,245,972	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1
Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	579,906				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		573,947			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	412	412	98,447,755		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	53,114	47,155	8,237,238	-80,199,969	5.00
7.00 00700	OPERATION OF PLANT	158,171	158,171	747,172	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	6,650	6,650	1,264	0	9.00
10.00 01000	DIETARY	5,912	5,912	41,449	0	10.00
11.00 01100	CAFETERIA	4,291	4,291	26,562	0	11.00
13.00 01300	NURSING ADMINISTRATION	9,440	9,440	1,782,074	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,975	2,975	389,170	0	14.00
15.00 01500	PHARMACY	4,318	4,318	3,313,230	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	6,605	6,605	1,153,269	0	16.00
17.00 01700	SOCIAL SERVICE	289	289	2,525,669	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	132,587	132,587	27,541,801	0	30.00
31.00 03100	INTENSIVE CARE UNIT	10,788	10,788	4,538,704	0	31.00
31.01 02060	NEONATAL NICU	19,663	19,663	6,275,661	0	31.01
43.00 04300	NURSERY	1,280	1,280	781,978	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	32,944	32,944	5,200,506	0	50.00
50.01 05001	ENDOSCOPY	10,609	10,609	1,404,060	0	50.01
51.00 05100	RECOVERY ROOM	5,664	5,664	1,128,617	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	14,991	14,991	4,030,403	0	52.00
53.00 05300	ANESTHESIOLOGY	529	529	92,551	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,707	14,707	2,581,567	0	54.00
54.01 03630	ULTRASOUND	1,122	1,122	1,165,010	0	54.01
54.02 05401	RADIOLOGY-SPECIAL PROCEDURES	1,030	1,030	660,054	0	54.02
54.03 03440	MAMMOGRAPHY	4,907	4,907	1,057,262	0	54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	12,428	12,428	817,478	0	55.00
56.00 05600	RADIOISOTOPE	2,127	2,127	428,601	0	56.00
57.00 05700	CT SCAN	2,664	2,664	1,043,611	0	57.00
58.00 05800	MRI	2,050	2,050	739,320	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	6,678	6,678	1,462,213	0	59.00
60.00 06000	LABORATORY	13,472	13,472	2,358,330	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	543	543	383,407	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	259,336	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,437	1,437	1,847,384	0	65.00
66.00 06600	PHYSICAL THERAPY	5,347	5,347	2,204,760	0	66.00
66.01 06601	REHAB OUTPATIENT	119	119	1,538,925	0	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	952,180	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	556	556	191,336	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001	PROCEDURE CLINIC	6,372	6,372	2,067,108	0	90.02
90.03 09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04 09002	EPILEPSY MONITORING UNIT	0	0	175,193	0	90.04
90.05 09003	OFFSITE IMAGING CENTER	0	0	441,844	0	90.05
91.00 09100	EMERGENCY	20,740	20,740	6,725,561	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	577,531	571,572	98,311,858	-80,199,969	227,403,696
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,375	2,375	135,645	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	POB	0	0	0	613,721	192.01
194.00 07950	COMMUNITY PROGRAMS	0	0	252	0	194.00
194.01 07951	VACANT SPACE	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					4.00
202.00	Cost to be allocated (per Wkst. B, Part I)	29,733,691	8,512,281	13,735,608		80,199,969	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	51.273294	14.831127	0.139522		0.351586	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			27,235		3,424,974	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000277		0.015015	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)		
		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	368,209				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,119,428			8.00	
9.00	00900	HOUSEKEEPING	6,650	0	361,559		9.00	
10.00	01000	DIETARY	5,912	0	5,912	72,831	10.00	
11.00	01100	CAFETERIA	4,291	0	4,291	0	11.00	
13.00	01300	NURSING ADMINISTRATION	9,440	0	9,440	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	2,975	0	2,975	0	14.00	
15.00	01500	PHARMACY	4,318	0	4,318	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	6,605	0	6,605	0	16.00	
17.00	01700	SOCIAL SERVICE	289	0	289	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	132,587	1,207,622	132,587	67,636	43,753	30.00
31.00	03100	INTENSIVE CARE UNIT	10,788	105,892	10,788	5,195	5,695	31.00
31.01	02060	NEONATAL NICU	19,663	18,158	19,663	0	7,267	31.01
43.00	04300	NURSERY	1,280	0	1,280	0	1,048	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,944	250,710	32,944	0	6,915	50.00
50.01	05001	ENDOSCOPY	10,609	0	10,609	0	1,954	50.01
51.00	05100	RECOVERY ROOM	5,664	0	5,664	0	1,275	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,991	135,347	14,991	0	5,172	52.00
53.00	05300	ANESTHESIOLOGY	529	0	529	0	219	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,707	5,214	14,707	0	5,034	54.00
54.01	03630	ULTRASOUND	1,122	60,400	1,122	0	1,269	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	1,030	0	1,030	0	707	54.02
54.03	03440	MAMMOGRAPHY	4,907	0	4,907	0	1,476	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	12,428	16,112	12,428	0	746	55.00
56.00	05600	RADIOISOTOPE	2,127	0	2,127	0	443	56.00
57.00	05700	CT SCAN	2,664	74,137	2,664	0	1,317	57.00
58.00	05800	MRI	2,050	0	2,050	0	972	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,678	0	6,678	0	1,304	59.00
60.00	06000	LABORATORY	13,472	0	13,472	0	5,197	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	543	0	543	0	646	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	301	64.00
65.00	06500	RESPIRATORY THERAPY	1,437	0	1,437	0	2,725	65.00
66.00	06600	PHYSICAL THERAPY	5,347	0	5,347	0	2,408	66.00
66.01	06601	REHAB OUTPATIENT	119	0	119	0	2,097	66.01
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	1,395	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	556	0	556	0	342	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	6,372	0	6,372	0	2,493	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	0	0	0	212	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0	0	0	658	90.05
91.00	09100	EMERGENCY	20,740	245,836	20,740	0	9,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	365,834	2,119,428	359,184	72,831	127,459	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,375	0	2,375	0	869	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	530	192.00
192.01	19201	POB	0	0	0	0	1,528	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	27,568,638	1,725,413	7,561,236	5,639,302	2,327,885	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	74.872255	0.814094	20.912869	77.429968	17.853796	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	10,762,276	19,168	712,433	631,627	438,831	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	29.228715	0.009044	1.970447	8.672502	3.365630	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description		NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	85,297					13.00
14.00	01400	0	25,730,127				14.00
15.00	01500	0	0	14,369,300			15.00
16.00	01600	0	0	0	1,556,372,382		16.00
17.00	01700	0	0	0	0	83,854	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	43,753	0	0	177,863,798	63,669	30.00
31.00	03100	5,695	0	0	23,798,045	5,195	31.00
31.01	02060	7,267	0	0	46,590,319	7,780	31.01
43.00	04300	1,048	0	0	11,008,987	7,210	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,915	0	0	131,853,211	0	50.00
50.01	05001	1,954	0	0	55,089,901	0	50.01
51.00	05100	1,275	0	0	22,655,059	0	51.00
52.00	05200	5,172	0	0	31,955,894	0	52.00
53.00	05300	0	0	0	30,109,825	0	53.00
54.00	05400	0	0	0	41,749,203	0	54.00
54.01	03630	0	0	0	33,927,352	0	54.01
54.02	05401	0	0	0	8,739,089	0	54.02
54.03	03440	0	0	0	17,162,395	0	54.03
55.00	05500	0	0	0	20,773,053	0	55.00
56.00	05600	0	0	0	25,096,887	0	56.00
57.00	05700	0	0	0	98,055,699	0	57.00
58.00	05800	0	0	0	47,196,221	0	58.00
59.00	05900	0	0	0	28,743,799	0	59.00
60.00	06000	0	0	0	181,814,054	0	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	0	0	0	8,210,522	0	63.00
64.00	06400	0	0	0	3,610,428	0	64.00
65.00	06500	0	0	0	33,570,805	0	65.00
66.00	06600	0	0	0	20,625,423	0	66.00
66.01	06601	0	0	0	11,494,520	0	66.01
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	36,829,448	0	69.00
70.00	07000	0	0	0	4,649,996	0	70.00
71.00	07100	0	11,491,117	0	79,855,062	0	71.00
72.00	07200	0	14,239,010	0	27,214,054	0	72.00
73.00	07300	0	0	14,369,300	139,095,006	0	73.00
74.00	07400	0	0	0	4,350,356	0	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	2,493	0	0	13,610,643	0	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	212	0	0	945,187	0	90.04
90.05	09003	0	0	0	11,485,846	0	90.05
91.00	09100	9,513	0	0	126,642,295	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		85,297	25,730,127	14,369,300	1,556,372,382	83,854	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		5,003,920	1,692,993	10,791,673	5,435,799	4,364,697	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description		NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	58.664666	0.065798	0.751023	0.003493	52.051148	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	970,114	308,626	548,849	705,687	87,148	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	11.373366	0.011995	0.038196	0.000453	1.039283	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/28/2016 2:11 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		86,602,819	0	86,602,819	30.00	
31.00	03100 INTENSIVE CARE UNIT		11,571,556	0	11,571,556	31.00	
31.01	02060 NEONATAL NICU		16,166,183	0	16,166,183	31.01	
43.00	04300 NURSERY		2,039,209	0	2,039,209	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		19,495,174	0	19,495,174	50.00	
50.01	05001 ENDOSCOPY		5,014,532	0	5,014,532	50.01	
51.00	05100 RECOVERY ROOM		3,149,114	0	3,149,114	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		10,664,109	0	10,664,109	52.00	
53.00	05300 ANESTHESIOLOGY		698,069	0	698,069	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,500,046	0	7,500,046	54.00	
54.01	03630 ULTRASOUND		2,363,831	0	2,363,831	54.01	
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES		1,407,224	0	1,407,224	54.02	
54.03	03440 MAMMOGRAPHY		2,918,977	0	2,918,977	54.03	
55.00	05500 RADIOLOGY-THERAPEUTIC		3,779,078	0	3,779,078	55.00	
56.00	05600 RADIOISOTOPE		2,808,747	0	2,808,747	56.00	
57.00	05700 CT SCAN		2,719,734	0	2,719,734	57.00	
58.00	05800 MRI		1,874,919	0	1,874,919	58.00	
59.00	05900 CARDIAC CATHETERIZATION		4,049,393	0	4,049,393	59.00	
60.00	06000 LABORATORY		15,388,386	0	15,388,386	60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		1,987,705	0	1,987,705	63.00	
64.00	06400 INTRAVENOUS THERAPY		512,530	0	512,530	64.00	
65.00	06500 RESPIRATORY THERAPY	0	4,245,936	0	4,245,936	65.00	
66.00	06600 PHYSICAL THERAPY	0	4,778,172	0	4,778,172	66.00	
66.01	06601 REHAB OUTPATIENT	0	2,821,861	0	2,821,861	66.01	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY		1,795,600	0	1,795,600	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		451,030	0	451,030	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		16,566,233	0	16,566,233	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		20,378,074	0	20,378,074	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		26,808,765	0	26,808,765	73.00	
74.00	07400 RENAL DIALYSIS		1,238,097	0	1,238,097	74.00	
76.97	07697 CARDIAC REHABILITATION		0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.02	09001 PROCEDURE CLINIC		4,990,093	0	4,990,093	90.02	
90.03	09004 IMMEDIATE CARE CENTER		0	0	0	90.03	
90.04	09002 EPILEPSY MONITORING UNIT		428,579	0	428,579	90.04	
90.05	09003 OFFSITE IMAGING CENTER		855,436	0	855,436	90.05	
91.00	09100 EMERGENCY		19,006,783	0	19,006,783	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		10,165,057	0	10,165,057	92.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		317,241,051	0	317,241,051	200.00	
201.00	Less Observation Beds		10,165,057		10,165,057	201.00	
202.00	Total (see instructions)		307,075,994	0	307,075,994	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/28/2016 2:11 pm		
			Title XVII I			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	157,080,187		157,080,187				30.00
31.00	03100	INTENSIVE CARE UNIT	23,798,045		23,798,045				31.00
31.01	02060	NEONATAL NICU	46,590,319		46,590,319				31.01
43.00	04300	NURSERY	11,008,987		11,008,987				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	53,438,465	78,414,746	131,853,211	0.147855	0.000000		50.00
50.01	05001	ENDOSCOPY	10,042,474	45,047,427	55,089,901	0.091025	0.000000		50.01
51.00	05100	RECOVERY ROOM	9,206,358	13,448,701	22,655,059	0.139003	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,781,963	2,173,931	31,955,894	0.333713	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	11,657,132	18,452,693	30,109,825	0.023184	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,478,647	28,270,556	41,749,203	0.179645	0.000000		54.00
54.01	03630	ULTRASOUND	8,073,509	25,853,843	33,927,352	0.069673	0.000000		54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	4,542,897	4,196,192	8,739,089	0.161026	0.000000		54.02
54.03	03440	MAMMOGRAPHY	2,229	17,160,166	17,162,395	0.170080	0.000000		54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	1,092,651	19,680,402	20,773,053	0.181922	0.000000		55.00
56.00	05600	RADIOISOTOPE	7,729,714	17,367,173	25,096,887	0.111916	0.000000		56.00
57.00	05700	CT SCAN	26,681,848	71,373,851	98,055,699	0.027737	0.000000		57.00
58.00	05800	MRI	11,911,060	35,285,161	47,196,221	0.039726	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	15,383,980	13,359,819	28,743,799	0.140879	0.000000		59.00
60.00	06000	LABORATORY	84,457,548	97,356,506	181,814,054	0.084638	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,468,491	1,742,031	8,210,522	0.242092	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	3,317,993	292,435	3,610,428	0.141958	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	30,007,245	3,563,560	33,570,805	0.126477	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	19,818,073	807,350	20,625,423	0.231664	0.000000		66.00
66.01	06601	REHAB OUTPATIENT	4,460	11,490,060	11,494,520	0.245496	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	16,810,533	20,018,915	36,829,448	0.048754	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	923,738	3,726,258	4,649,996	0.096996	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	48,091,141	31,763,921	79,855,062	0.207454	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,631,752	9,582,302	27,214,054	0.748807	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,493,197	50,601,809	139,095,006	0.192737	0.000000		73.00
74.00	07400	RENAL DIALYSIS	4,253,213	97,143	4,350,356	0.284597	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.02	09001	PROCEDURE CLINIC	296,824	13,313,819	13,610,643	0.366632	0.000000		90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0.000000	0.000000		90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	945,187	945,187	0.453433	0.000000		90.04
90.05	09003	OFFSITE IMAGING CENTER	19,271	11,466,575	11,485,846	0.074477	0.000000		90.05
91.00	09100	EMERGENCY	30,849,667	95,792,628	126,642,295	0.150082	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,604,741	14,178,870	20,783,611	0.489090	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	799,548,352	756,824,030	1,556,372,382				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	799,548,352	756,824,030	1,556,372,382				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/28/2016 2:11 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	02060 NEONATAL NICU			31.01
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.147855		50.00
50.01	05001 ENDOSCOPY	0.091025		50.01
51.00	05100 RECOVERY ROOM	0.139003		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.333713		52.00
53.00	05300 ANESTHESIOLOGY	0.023184		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.179645		54.00
54.01	03630 ULTRASOUND	0.069673		54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	0.161026		54.02
54.03	03440 MAMMOGRAPHY	0.170080		54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.181922		55.00
56.00	05600 RADIOISOTOPE	0.111916		56.00
57.00	05700 CT SCAN	0.027737		57.00
58.00	05800 MRI	0.039726		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.140879		59.00
60.00	06000 LABORATORY	0.084638		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.242092		63.00
64.00	06400 INTRAVENOUS THERAPY	0.141958		64.00
65.00	06500 RESPIRATORY THERAPY	0.126477		65.00
66.00	06600 PHYSICAL THERAPY	0.231664		66.00
66.01	06601 REHAB OUTPATIENT	0.245496		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.048754		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.096996		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.207454		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.748807		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.192737		73.00
74.00	07400 RENAL DIALYSIS	0.284597		74.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
	OUTPATIENT SERVICE COST CENTERS			
90.02	09001 PROCEDURE CLINIC	0.366632		90.02
90.03	09004 IMMEDIATE CARE CENTER	0.000000		90.03
90.04	09002 EPILEPSY MONITORING UNIT	0.453433		90.04
90.05	09003 OFFSITE IMAGING CENTER	0.074477		90.05
91.00	09100 EMERGENCY	0.150082		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.489090		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/28/2016 2:11 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		86,602,819	0	86,602,819	30.00	
31.00	03100 INTENSIVE CARE UNIT		11,571,556	0	11,571,556	31.00	
31.01	02060 NEONATAL NICU		16,166,183	0	16,166,183	31.01	
43.00	04300 NURSERY		2,039,209	0	2,039,209	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		19,495,174	0	19,495,174	50.00	
50.01	05001 ENDOSCOPY		5,014,532	0	5,014,532	50.01	
51.00	05100 RECOVERY ROOM		3,149,114	0	3,149,114	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		10,664,109	0	10,664,109	52.00	
53.00	05300 ANESTHESIOLOGY		698,069	0	698,069	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,500,046	0	7,500,046	54.00	
54.01	03630 ULTRASOUND		2,363,831	0	2,363,831	54.01	
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES		1,407,224	0	1,407,224	54.02	
54.03	03440 MAMMOGRAPHY		2,918,977	0	2,918,977	54.03	
55.00	05500 RADIOLOGY-THERAPEUTIC		3,779,078	0	3,779,078	55.00	
56.00	05600 RADIOISOTOPE		2,808,747	0	2,808,747	56.00	
57.00	05700 CT SCAN		2,719,734	0	2,719,734	57.00	
58.00	05800 MRI		1,874,919	0	1,874,919	58.00	
59.00	05900 CARDIAC CATHETERIZATION		4,049,393	0	4,049,393	59.00	
60.00	06000 LABORATORY		15,388,386	0	15,388,386	60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		1,987,705	0	1,987,705	63.00	
64.00	06400 INTRAVENOUS THERAPY		512,530	0	512,530	64.00	
65.00	06500 RESPIRATORY THERAPY	0	4,245,936	0	4,245,936	65.00	
66.00	06600 PHYSICAL THERAPY	0	4,778,172	0	4,778,172	66.00	
66.01	06601 REHAB OUTPATIENT	0	2,821,861	0	2,821,861	66.01	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY		1,795,600	0	1,795,600	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		451,030	0	451,030	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		16,566,233	0	16,566,233	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		20,378,074	0	20,378,074	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		26,808,765	0	26,808,765	73.00	
74.00	07400 RENAL DIALYSIS		1,238,097	0	1,238,097	74.00	
76.97	07697 CARDIAC REHABILITATION		0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.02	09001 PROCEDURE CLINIC		4,990,093	0	4,990,093	90.02	
90.03	09004 IMMEDIATE CARE CENTER		0	0	0	90.03	
90.04	09002 EPILEPSY MONITORING UNIT		428,579	0	428,579	90.04	
90.05	09003 OFFSITE IMAGING CENTER		855,436	0	855,436	90.05	
91.00	09100 EMERGENCY		19,006,783	0	19,006,783	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		10,165,057	0	10,165,057	92.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		317,241,051	0	317,241,051	200.00	
201.00	Less Observation Beds		10,165,057		10,165,057	201.00	
202.00	Total (see instructions)		307,075,994	0	307,075,994	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/28/2016 2:11 pm	
			Title XIX		Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	157,080,187		157,080,187			30.00
31.00	03100	INTENSIVE CARE UNIT	23,798,045		23,798,045			31.00
31.01	02060	NEONATAL NICU	46,590,319		46,590,319			31.01
43.00	04300	NURSERY	11,008,987		11,008,987			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	53,438,465	78,414,746	131,853,211	0.147855	0.000000	50.00
50.01	05001	ENDOSCOPY	10,042,474	45,047,427	55,089,901	0.091025	0.000000	50.01
51.00	05100	RECOVERY ROOM	9,206,358	13,448,701	22,655,059	0.139003	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,781,963	2,173,931	31,955,894	0.333713	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,657,132	18,452,693	30,109,825	0.023184	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,478,647	28,270,556	41,749,203	0.179645	0.000000	54.00
54.01	03630	ULTRASOUND	8,073,509	25,853,843	33,927,352	0.069673	0.000000	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	4,542,897	4,196,192	8,739,089	0.161026	0.000000	54.02
54.03	03440	MAMMOGRAPHY	2,229	17,160,166	17,162,395	0.170080	0.000000	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	1,092,651	19,680,402	20,773,053	0.181922	0.000000	55.00
56.00	05600	RADIOISOTOPE	7,729,714	17,367,173	25,096,887	0.111916	0.000000	56.00
57.00	05700	CT SCAN	26,681,848	71,373,851	98,055,699	0.027737	0.000000	57.00
58.00	05800	MRI	11,911,060	35,285,161	47,196,221	0.039726	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,383,980	13,359,819	28,743,799	0.140879	0.000000	59.00
60.00	06000	LABORATORY	84,457,548	97,356,506	181,814,054	0.084638	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,468,491	1,742,031	8,210,522	0.242092	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,317,993	292,435	3,610,428	0.141958	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	30,007,245	3,563,560	33,570,805	0.126477	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	19,818,073	807,350	20,625,423	0.231664	0.000000	66.00
66.01	06601	REHAB OUTPATIENT	4,460	11,490,060	11,494,520	0.245496	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	16,810,533	20,018,915	36,829,448	0.048754	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	923,738	3,726,258	4,649,996	0.096996	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	48,091,141	31,763,921	79,855,062	0.207454	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,631,752	9,582,302	27,214,054	0.748807	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,493,197	50,601,809	139,095,006	0.192737	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,253,213	97,143	4,350,356	0.284597	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	296,824	13,313,819	13,610,643	0.366632	0.000000	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	945,187	945,187	0.453433	0.000000	90.04
90.05	09003	OFFSITE IMAGING CENTER	19,271	11,466,575	11,485,846	0.074477	0.000000	90.05
91.00	09100	EMERGENCY	30,849,667	95,792,628	126,642,295	0.150082	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,604,741	14,178,870	20,783,611	0.489090	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	799,548,352	756,824,030	1,556,372,382			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	799,548,352	756,824,030	1,556,372,382			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/28/2016 2:11 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	02060 NEONATAL NICU			31.01
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
50.01	05001 ENDOSCOPY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630 ULTRASOUND	0.000000		54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	0.000000		54.02
54.03	03440 MAMMOGRAPHY	0.000000		54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
66.01	06601 REHAB OUTPATIENT	0.000000		66.01
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 PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
	OUTPATIENT SERVICE COST CENTERS			
90.02	09001 PROCEDURE CLINIC	0.000000		90.02
90.03	09004 IMMEDIATE CARE CENTER	0.000000		90.03
90.04	09002 EPILEPSY MONITORING UNIT	0.000000		90.04
90.05	09003 OFFSITE IMAGING CENTER	0.000000		90.05
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part I Date/Time Prepared: 11/28/2016 2:11 pm	
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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	14,968,805	0	14,968,805	72,136	207.51	30.00
31.00	INTENSIVE CARE UNIT	1,299,973		1,299,973	5,195	250.24	31.00
31.01	NEONATAL NICU	2,197,502		2,197,502	7,780	282.46	31.01
43.00	NURSERY	168,497		168,497	7,210	23.37	43.00
200.00	Total (Lines 30-199)	18,634,777		18,634,777	92,321		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	24,318	5,046,228				
31.00	INTENSIVE CARE UNIT	2,157	539,768				
31.01	NEONATAL NICU	0	0				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	26,475	5,585,996				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/28/2016 2:11 pm
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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		
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,539,185	131,853,211	0.026842	18,363,838	492,922	50.00
50.01	05001	ENDOSCOPY	1,127,057	55,089,901	0.020459	4,501,979	92,106	50.01
51.00	05100	RECOVERY ROOM	607,490	22,655,059	0.026815	3,186,373	85,443	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,647,381	31,955,894	0.051552	62,865	3,241	52.00
53.00	05300	ANESTHESIOLOGY	71,857	30,109,825	0.002386	4,037,772	9,634	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,532,664	41,749,203	0.036711	6,192,167	227,321	54.00
54.01	03630	ULTRASOUND	152,637	33,927,352	0.004499	3,851,034	17,326	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	120,803	8,739,089	0.013823	2,056,205	28,423	54.02
54.03	03440	MAMMOGRAPHY	516,751	17,162,395	0.030109	1,916	58	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	1,249,239	20,773,053	0.060137	436,773	26,266	55.00
56.00	05600	RADIOISOTOPE	247,821	25,096,887	0.009875	4,000,919	39,509	56.00
57.00	05700	CT SCAN	331,670	98,055,699	0.003382	11,560,968	39,099	57.00
58.00	05800	MRI	240,951	47,196,221	0.005105	5,195,163	26,521	58.00
59.00	05900	CARDIAC CATHETERIZATION	704,113	28,743,799	0.024496	5,775,694	141,481	59.00
60.00	06000	LABORATORY	1,560,567	181,814,054	0.008583	33,189,944	284,869	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	79,891	8,210,522	0.009730	1,545,969	15,042	63.00
64.00	06400	INTRAVENOUS THERAPY	8,215	3,610,428	0.002275	1,692,896	3,851	64.00
65.00	06500	RESPIRATORY THERAPY	208,514	33,570,805	0.006211	14,111,253	87,645	65.00
66.00	06600	PHYSICAL THERAPY	584,454	20,625,423	0.028337	10,605,751	300,535	66.00
66.01	06601	REHAB OUTPATIENT	54,630	11,494,520	0.004753	3,463	16	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,885	36,829,448	0.001083	8,114,707	8,788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61,582	4,649,996	0.013243	336,607	4,458	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	346,549	79,855,062	0.004340	17,785,897	77,191	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	398,037	27,214,054	0.014626	7,555,896	110,513	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	784,398	139,095,006	0.005639	35,438,027	199,835	73.00
74.00	07400	RENAL DIALYSIS	15,556	4,350,356	0.003576	2,403,549	8,595	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	709,510	13,610,643	0.052129	102,243	5,330	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0.000000	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	8,146	945,187	0.008618	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	16,467	11,485,846	0.001434	16,474	24	90.05
91.00	09100	EMERGENCY	2,393,600	126,642,295	0.018900	12,722,745	240,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,756,969	20,783,611	0.084536	2,683,359	226,840	92.00
200.00		Total (lines 50-199)	21,116,589	1,317,894,844		217,532,446	2,803,342	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part III Date/Time Prepared: 11/28/2016 2:11 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			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	0	31.00
31.01	02060	NEONATAL NICU	0	0	0	0	0	31.01
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	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	72,136	0.00	24,318	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,195	0.00	2,157	0		31.00
31.01	02060	NEONATAL NICU	7,780	0.00	0	0		31.01
43.00	04300	NURSERY	7,210	0.00	0	0		43.00
200.00		Total (lines 30-199)	92,321		26,475	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/28/2016 2:11 pm
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
50.01	05001	ENDOSCOPY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03630	ULTRASOUND	0	0	0	0	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	0	54.02
54.03	03440	MAMMOGRAPHY	0	0	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	REHAB OUTPATIENT	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	PROCEDURE CLINIC	0	0	0	0	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	0	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/28/2016 2:11 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	131,853,211	0.000000	0.000000	18,363,838	50.00
50.01	05001 ENDOSCOPY	0	55,089,901	0.000000	0.000000	4,501,979	50.01
51.00	05100 RECOVERY ROOM	0	22,655,059	0.000000	0.000000	3,186,373	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	31,955,894	0.000000	0.000000	62,865	52.00
53.00	05300 ANESTHESIOLOGY	0	30,109,825	0.000000	0.000000	4,037,772	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	41,749,203	0.000000	0.000000	6,192,167	54.00
54.01	03630 ULTRASOUND	0	33,927,352	0.000000	0.000000	3,851,034	54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	0	8,739,089	0.000000	0.000000	2,056,205	54.02
54.03	03440 MAMMOGRAPHY	0	17,162,395	0.000000	0.000000	1,916	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0	20,773,053	0.000000	0.000000	436,773	55.00
56.00	05600 RADIOISOTOPE	0	25,096,887	0.000000	0.000000	4,000,919	56.00
57.00	05700 CT SCAN	0	98,055,699	0.000000	0.000000	11,560,968	57.00
58.00	05800 MRI	0	47,196,221	0.000000	0.000000	5,195,163	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	28,743,799	0.000000	0.000000	5,775,694	59.00
60.00	06000 LABORATORY	0	181,814,054	0.000000	0.000000	33,189,944	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	8,210,522	0.000000	0.000000	1,545,969	63.00
64.00	06400 INTRAVENOUS THERAPY	0	3,610,428	0.000000	0.000000	1,692,896	64.00
65.00	06500 RESPIRATORY THERAPY	0	33,570,805	0.000000	0.000000	14,111,253	65.00
66.00	06600 PHYSICAL THERAPY	0	20,625,423	0.000000	0.000000	10,605,751	66.00
66.01	06601 REHAB OUTPATIENT	0	11,494,520	0.000000	0.000000	3,463	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	36,829,448	0.000000	0.000000	8,114,707	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	4,649,996	0.000000	0.000000	336,607	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	79,855,062	0.000000	0.000000	17,785,897	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	27,214,054	0.000000	0.000000	7,555,896	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	139,095,006	0.000000	0.000000	35,438,027	73.00
74.00	07400 RENAL DIALYSIS	0	4,350,356	0.000000	0.000000	2,403,549	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001 PROCEDURE CLINIC	0	13,610,643	0.000000	0.000000	102,243	90.02
90.03	09004 IMMEDIATE CARE CENTER	0	0	0.000000	0.000000	0	90.03
90.04	09002 EPILEPSY MONITORING UNIT	0	945,187	0.000000	0.000000	0	90.04
90.05	09003 OFFSITE IMAGING CENTER	0	11,485,846	0.000000	0.000000	16,474	90.05
91.00	09100 EMERGENCY	0	126,642,295	0.000000	0.000000	12,722,745	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	20,783,611	0.000000	0.000000	2,683,359	92.00
200.00	Total (lines 50-199)	0	1,317,894,844			217,532,446	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/28/2016 2:11 pm
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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	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	11,108,143	0	50.00
50.01	05001 ENDOSCOPY	0	13,050,703	0	50.01
51.00	05100 RECOVERY ROOM	0	1,497,511	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	5,866	0	52.00
53.00	05300 ANESTHESIOLOGY	0	2,716,851	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,263,555	0	54.00
54.01	03630 ULTRASOUND	0	3,771,944	0	54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	0	1,560,900	0	54.02
54.03	03440 MAMMOGRAPHY	0	1,059,251	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0	7,322,666	0	55.00
56.00	05600 RADIOISOTOPE	0	5,990,148	0	56.00
57.00	05700 CT SCAN	0	15,429,952	0	57.00
58.00	05800 MRI	0	8,407,674	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	7,083,252	0	59.00
60.00	06000 LABORATORY	0	10,826,518	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0	313,970	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	94,958	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	894,090	0	65.00
66.00	06600 PHYSICAL THERAPY	0	8,346	0	66.00
66.01	06601 REHAB OUTPATIENT	0	50,930	0	66.01
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	4,930,616	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	868,379	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,700,239	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3,026,953	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13,881,917	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.02	09001 PROCEDURE CLINIC	0	5,756,752	0	90.02
90.03	09004 IMMEDIATE CARE CENTER	0	0	0	90.03
90.04	09002 EPILEPSY MONITORING UNIT	0	39,250	0	90.04
90.05	09003 OFFSITE IMAGING CENTER	0	2,549,370	0	90.05
91.00	09100 EMERGENCY	0	12,118,982	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,794,032	0	92.00
200.00	Total (lines 50-199)	0	149,123,718	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/28/2016 2:11 pm				
		Title XVIII	Hospital	PPS				
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.147855	11,108,143	0	1,952	1,642,394	50.00
50.01	05001	ENDOSCOPY	0.091025	13,050,703	0	978	1,187,940	50.01
51.00	05100	RECOVERY ROOM	0.139003	1,497,511	0	183	208,159	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.333713	5,866	0	18	1,958	52.00
53.00	05300	ANESTHESIOLOGY	0.023184	2,716,851	0	0	62,987	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179645	5,263,555	0	375	945,571	54.00
54.01	03630	ULTRASOUND	0.069673	3,771,944	0	0	262,803	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0.161026	1,560,900	0	442	251,345	54.02
54.03	03440	MAMMOGRAPHY	0.170080	1,059,251	0	0	180,157	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.181922	7,322,666	0	0	1,332,154	55.00
56.00	05600	RADIO SOTOPE	0.111916	5,990,148	0	0	670,393	56.00
57.00	05700	CT SCAN	0.027737	15,429,952	0	8,089	427,981	57.00
58.00	05800	MRI	0.039726	8,407,674	0	1,617	334,003	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.140879	7,083,252	0	2,108	997,881	59.00
60.00	06000	LABORATORY	0.084638	10,826,518	0	0	916,335	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.242092	313,970	0	5	76,010	63.00
64.00	06400	INTRAVENOUS THERAPY	0.141958	94,958	0	0	13,480	64.00
65.00	06500	RESPIRATORY THERAPY	0.126477	894,090	0	0	113,082	65.00
66.00	06600	PHYSICAL THERAPY	0.231664	8,346	0	0	1,933	66.00
66.01	06601	REHAB OUTPATIENT	0.245496	50,930	0	0	12,503	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048754	4,930,616	0	0	240,387	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.096996	868,379	0	0	84,229	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.207454	6,700,239	0	0	1,389,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.748807	3,026,953	0	567	2,266,604	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192737	13,881,917	0	125,492	2,675,559	73.00
74.00	07400	RENAL DIALYSIS	0.284597	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	0.366632	5,756,752	0	2,626	2,110,609	90.02
90.03	09004	IMMEDIATE CARE CENTER	0.000000	0	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0.453433	39,250	0	0	17,797	90.04
90.05	09003	OFFSITE IMAGING CENTER	0.074477	2,549,370	0	184	189,869	90.05
91.00	09100	EMERGENCY	0.150082	12,118,982	69,407	433	1,818,841	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.489090	2,794,032	0	9	1,366,533	92.00
200.00		Subtotal (see instructions)		149,123,718	69,407	145,078	21,799,488	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		149,123,718	69,407	145,078	21,799,488	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/28/2016 2:11 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	289	50.00
50.01	05001	ENDOSCOPY	0	89	50.01
51.00	05100	RECOVERY ROOM	0	25	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67	54.00
54.01	03630	ULTRASOUND	0	0	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	71	54.02
54.03	03440	MAMMOGRAPHY	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	224	57.00
58.00	05800	MRI	0	64	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	297	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	REHAB OUTPATIENT	0	0	66.01
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 PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	425	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,187	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.02	09001	PROCEDURE CLINIC	0	963	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	14	90.05
91.00	09100	EMERGENCY	10,417	65	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4	92.00
200.00		Subtotal (see instructions)	10,417	26,791	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	10,417	26,791	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 2:11 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		72,136	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		72,136	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)		63,669	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)		24,318	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)		86,602,819	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)		86,602,819	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)		86,602,819	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)		1,200.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		29,194,975	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)		29,194,975	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		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	11,571,556	5,195	2,227.44	2,157	4,804,588	43.00
43.01	NEONATAL NICU	16,166,183	7,780	2,077.92	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					35,479,625	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					69,479,188	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)					5,585,996	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,803,342	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					8,389,338	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					61,089,850	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)					8,467	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,200.55	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					10,165,057	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/28/2016 2:11 pm	
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	14,968,805	86,602,819	0.172844	10,165,057	1,756,969	90.00
91.00	Nursing School cost	0	86,602,819	0.000000	10,165,057	0	91.00
92.00	Allied health cost	0	86,602,819	0.000000	10,165,057	0	92.00
93.00	All other Medical Education	0	86,602,819	0.000000	10,165,057	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 2:11 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		72,136	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		72,136	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)		63,669	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)		3,332	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)		7,210	15.00
16.00	Nursery days (title V or XIX only)		739	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)		86,602,819	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)		86,602,819	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)		86,602,819	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)		1,200.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,000,233	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)		4,000,233	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 11/28/2016 2:11 pm	
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)	2,039,209	7,210	282.83	739	209,011	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	11,571,556	5,195	2,227.44	263	585,817	43.00
43.01	NEONATAL NICU	16,166,183	7,780	2,077.92	1,463	3,039,997	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,835,058	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)					8,467	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,200.55	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					10,165,057	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/28/2016 2:11 pm	
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	14,968,805	86,602,819	0.172844	10,165,057	1,756,969	90.00
91.00	Nursing School cost	0	86,602,819	0.000000	10,165,057	0	91.00
92.00	Allied health cost	0	86,602,819	0.000000	10,165,057	0	92.00
93.00	All other Medical Education	0	86,602,819	0.000000	10,165,057	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/28/2016 2:11 pm	
Cost Center Description		Title XVII	Hospital	PPS	
		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		59,897,058	30.00
31.00	03100	INTENSIVE CARE UNIT		11,043,413	31.00
31.01	02060	NEONATAL NICU		0	31.01
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.147855	18,363,838	50.00
50.01	05001	ENDOSCOPY	0.091025	4,501,979	50.01
51.00	05100	RECOVERY ROOM	0.139003	3,186,373	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.333713	62,865	52.00
53.00	05300	ANESTHESIOLOGY	0.023184	4,037,772	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179645	6,192,167	54.00
54.01	03630	ULTRASOUND	0.069673	3,851,034	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0.161026	2,056,205	54.02
54.03	03440	MAMMOGRAPHY	0.170080	1,916	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.181922	436,773	55.00
56.00	05600	RADIOISOTOPE	0.111916	4,000,919	56.00
57.00	05700	CT SCAN	0.027737	11,560,968	57.00
58.00	05800	MRI	0.039726	5,195,163	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.140879	5,775,694	59.00
60.00	06000	LABORATORY	0.084638	33,189,944	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.242092	1,545,969	63.00
64.00	06400	INTRAVENOUS THERAPY	0.141958	1,692,896	64.00
65.00	06500	RESPIRATORY THERAPY	0.126477	14,111,253	65.00
66.00	06600	PHYSICAL THERAPY	0.231664	10,605,751	66.00
66.01	06601	REHAB OUTPATIENT	0.245496	3,463	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048754	8,114,707	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.096996	336,607	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.207454	17,785,897	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.748807	7,555,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192737	35,438,027	73.00
74.00	07400	RENAL DIALYSIS	0.284597	2,403,549	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.02	09001	PROCEDURE CLINIC	0.366632	102,243	90.02
90.03	09004	IMMEDIATE CARE CENTER	0.000000	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0.453433	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0.074477	16,474	90.05
91.00	09100	EMERGENCY	0.150082	12,722,745	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.489090	2,683,359	92.00
200.00		Total (sum of lines 50-94 and 96-98)		217,532,446	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)		217,532,446	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/28/2016 2:11 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)		10,486,197	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		32,562,716	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)		2,549,263	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)		270.87	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)		2.28	30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.62	31.00
32.00	Sum of lines 30 and 31		27.90	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.23	33.00
34.00	Disproportionate share adjustment (see instructions)		1,316,221	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/28/2016 2:11 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000523947	0.000513388	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	4,006,959	3,288,838	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,009,974	2,462,136	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,472,110		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	50,386,507		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)		50,386,507	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4,053,847	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		3,240	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		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)		54,443,594	59.00
60.00	Primary payer payments		367,431	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		54,076,163	61.00
62.00	Deductibles billed to program beneficiaries		4,423,804	62.00
63.00	Coinurance billed to program beneficiaries		276,899	63.00
64.00	Allowable bad debts (see instructions)		712,035	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		462,823	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		440,650	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		49,838,283	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.01	OTHER ADJUSTMENTS		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)		25,813	70.93
70.94	HRR adjustment amount (see instructions)		-73,904	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/28/2016 2:11 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			49,790,192	71.00
71.01	Sequestration adjustment (see instructions)			995,804	71.01
72.00	Interim payments			48,403,579	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)			390,809	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			154,347	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	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	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	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2016 2:11 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,486,197	0	10,486,197		10,486,197	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	32,562,716	0		32,562,716	32,562,716	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	2,549,263	0	476,074	2,073,189	2,549,263	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	0.1223	0.1223	0.1223	0.1223		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,316,221	0	320,616	995,605	1,316,221	11.00
11.01	Uncompensated care payments	36.00	3,472,110	0	4,009,721	0	4,009,721	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	50,386,507	0	15,292,608	35,093,899	50,386,507	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	50,386,507	0	15,292,608	35,093,899	50,386,507	15.00
16.00	Payment for inpatient program capital	50.00	4,053,847	0	945,690	3,108,157	4,053,847	16.00
17.00	Special add-on payments for new technologies	54.00	3,240	0	0	3,240	3,240	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2016 2:11 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	16,238,298	38,205,296	54,443,594	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	3,450,304	0	838,368	2,611,936	3,450,304	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	403,080	0	58,613	344,467	403,080	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	0.0581	0.0581	0.0581	0.0581		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	200,463	0	48,709	151,754	200,463	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,053,847	0	945,690	3,108,157	4,053,847	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2016 2:11 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 (col s. 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	10,486,197	10,486,197		1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	32,562,716		32,562,716	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	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	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00	2,549,263	476,074	2,073,189	2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	2.01	
3.00	Operating outlier reconciliation	2.01	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	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	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	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	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	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	9.01	
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1223	0.1223	0.1223	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	1,316,221	320,616	995,605	11.00	
11.01	Uncompensated care payments	36.00	3,472,110	1,009,974	0	11.01	
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	50,386,507	12,292,861	38,093,646	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	50,386,507	12,292,861	38,093,646	15.00	
16.00	Payment for inpatient program capital	50.00	4,053,847	945,690	3,108,157	16.00	
17.00	Special add-on payments for new technologies	54.00	3,240	0	3,240	17.00	
17.01	Net organ acquisition cost	55.00	0	0	0	17.01	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	17.02	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	18.00	
19.00	SUBTOTAL			13,238,551	41,205,043	54,443,594	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2016 2:11 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	3,450,304	838,368	2,611,936	3,450,304	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	403,080	58,613	344,467	403,080	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	0.0581	0.0581	0.0581		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	200,463	48,709	151,754	200,463	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,053,847	945,690	3,108,157	4,053,847	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	25,813	-1,453	27,266	25,813	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	-73,904	-28,312	-45,592	-73,904	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: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/28/2016 2:11 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		37,208	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		21,799,488	2.00
3.00	PPS payments		20,543,127	3.00
4.00	Outlier payment (see instructions)		47,068	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)		37,208	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		214,485	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)		214,485	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 charge basis 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)		214,485	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		177,277	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)		37,208	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)		20,590,195	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		13,887	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,230,885	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)		16,382,631	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)		16,382,631	30.00
31.00	Primary payer payments		28,735	31.00
32.00	Subtotal (line 30 minus line 31)		16,353,896	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)		754,357	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		490,332	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		514,739	36.00
37.00	Subtotal (see instructions)		16,844,228	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-337	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)		16,844,565	40.00
40.01	Sequestration adjustment (see instructions)		336,891	40.01
41.00	Interim payments		16,494,507	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		13,167	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: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2016 2:11 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		47,845,698		16,009,349	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		519,981		485,158	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	01/18/2016	37,900		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)		37,900		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)		48,403,579		16,494,507	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		390,809		13,167	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		48,794,388		16,507,674	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: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet E-1
Part II
Date/Time Prepared:
11/28/2016 2:11 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	17,420	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	26,475	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	5,682	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	76,644	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,556,372,382	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	26,881,065	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)	1,121,509	8.00
9.00	Sequestration adjustment amount (see instructions)	22,430	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,099,079	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	954,248	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)	144,831	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2016 2: 11 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		7,835,058		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		7,835,058	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		7,835,058	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		7,835,058	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		7,835,058	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet G

Date/Time Prepared:
11/28/2016 2:11 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	11,000	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	47,647,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,554,000	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,154,000	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	53,366,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	12,220,000	0	0	0	12.00
13.00	Land improvements	185,321	0	0	0	13.00
14.00	Accumulated depreciation	-23,043	0	0	0	14.00
15.00	Buildings	245,988,577	0	0	0	15.00
16.00	Accumulated depreciation	-34,653,090	0	0	0	16.00
17.00	Leasehold improvements	8,357,549	0	0	0	17.00
18.00	Accumulated depreciation	-3,549,816	0	0	0	18.00
19.00	Fixed equipment	1,460,605	0	0	0	19.00
20.00	Accumulated depreciation	-527,375	0	0	0	20.00
21.00	Automobiles and trucks	23,541	0	0	0	21.00
22.00	Accumulated depreciation	-21,740	0	0	0	22.00
23.00	Major movable equipment	43,114,896	0	0	0	23.00
24.00	Accumulated depreciation	-22,203,890	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)	250,371,535	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,297,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	407,465	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,704,465	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	305,442,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,007,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,040,000	0	0	0	38.00
39.00	Payroll taxes payable	0	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	0	0	0	42.00
43.00	Due to other funds	49,576,000	0	0	0	43.00
44.00	Other current liabilities	21,554,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	82,177,000	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	8,043,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,043,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	90,220,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	215,222,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	215,222,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	305,442,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet G-1

Date/Time Prepared:
11/28/2016 2:11 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		234,299,903		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		55,904,202			2.00
3.00	Total (sum of line 1 and line 2)		290,204,105		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00	ROUNDING	584		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		584		0	10.00
11.00	Subtotal (line 3 plus line 10)		290,204,689		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	TRANSFERS	74,982,689		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		74,982,689		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		215,222,000		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00	ROUNDING		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	TRANSFERS		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2016 2:11 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	157,080,187		157,080,187	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)	157,080,187		157,080,187	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	23,798,045		23,798,045	11.00
11.01	NEONATAL NICU	46,590,319		46,590,319	11.01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	70,388,364		70,388,364	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	227,468,551		227,468,551	17.00
18.00	Ancillary services	561,070,814	756,824,029	1,317,894,843	18.00
19.00	Outpatient services	0	0	0	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	NURSERY & CAPITATION	11,008,987	857,691	11,866,678	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	799,548,352	757,681,720	1,557,230,072	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		303,334,382		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		303,334,382		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140290

Period:
From 07/01/2015
To 06/30/2016

Worksheet G-3

Date/Time Prepared:
11/28/2016 2:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,557,230,072	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,204,138,000	2.00
3.00	Net patient revenues (line 1 minus line 2)	353,092,072	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	303,334,382	4.00
5.00	Net income from service to patients (line 3 minus line 4)	49,757,690	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	1,026,947	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	54,666	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	368,138	20.00
21.00	Rental of vending machines	10,355	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEANINGFUL USE	954,248	24.00
24.01	POB RENT	1,992,957	24.01
24.02	FOUNDATION RESTRICTED FUNDS	281,010	24.02
24.03	INCOME FROM EASEMENT	0	24.03
24.04	SURGICENTER JV	965,371	24.04
24.05	INTERCOMPANY RENT	0	24.05
24.06	STARBUCKS	495,152	24.06
24.07	INTERCOMPANY LAB	73,953	24.07
24.08	MISCELLANEOUS INCOME	560,715	24.08
25.00	Total other income (sum of lines 6-24)	6,783,512	25.00
26.00	Total (line 5 plus line 25)	56,541,202	26.00
27.00	OTHER NON RECURRING ITEMS	637,000	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	637,000	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	55,904,202	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140290	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/28/2016 2: 11 pm
		Title XVII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,450,304	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		403,080	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)		209.41	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)		2.28	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		25.62	8.00
9.00	Sum of lines 7 and 8		27.90	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.81	10.00
11.00	Disproportionate share adjustment (see instructions)		200,463	11.00
12.00	Total prospective capital payments (see instructions)		4,053,847	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